



**UNIVERSAL
CURRICULUM**
Treatment of Substance Use Disorders

The Universal Treatment Curriculum for
Substance Use Disorders (UTC)

Participant Manual

UTC 4



Basic Counseling Skills for Addiction Professionals

4th Edition, 2020



DAP
Drug Advisory Programme



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*The Universal Treatment Curriculum for
Substance Use Disorders (UTC)*

Basic Level UTC Series - UTC 4



Basic Counseling Skills for Addiction Professionals

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Acknowledgments

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Disclaimer

The substance use disorder treatment interventions described or referred to herein do not necessarily reflect the official position of INL or the U.S. Department of State. The guidelines in this document should not be considered substitutes for individualized client care.

4th Edition

Published 2020 - Sri Lanka

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PARTICIPANT ORIENTATION

Introduction

Welcome! This training will provide you with an understanding of the physiology of addiction as a brain disease and teach you about the effects and consequences of psychoactive substances.

Course 4: *Basic Counseling Skills for Addiction Professionals* is part of a training series developed through funding from the U.S. Department of State to The Colombo Plan Drug Advisory Programme (DAP). More information on the Colombo Plan can be found at <http://www.colombo-plan.org>.

The overall goal of the training series is to reduce the significant health, social, and economic problems associated with substance use disorders (SUDs) by building international treatment capacity through training, professionalizing, and expanding the global treatment workforce. The training prepares counselors for professional certification at the entry level by providing the latest information about SUDs and their treatment and facilitating hands-on activities to develop skills, confidence, and competence.

Congratulations for taking the time to learn more about your work!

The Training

The eight modules in this training series may be delivered over 5 consecutive days or may be offered over the course of several weeks or months. Your trainers have provided you with a specific agenda.

The learning approach for this training includes:

- Trainer-led presentations and discussions;
- Frequent use of creative learner-directed activities, such as small-group and partner-to-partner exercises and presentations;
- Reflective writing exercises;
- Periodic reviews to enhance learning retention; and
- Learning assessment exercises.

Your active participation is essential to making this a positive and productive learning experience!

Goals and Objectives for Course 4

Training goals

- To provide an opportunity for participants to learn and practice basic skills they will need in all settings and models of treatment; and
- To teach and provide an opportunity for participants to practice basic group counseling skills.

Learning objectives

Participants who complete Course 4 will be able to:

- Describe the concept and importance of counselor style;
- List at least five characteristics of effective counselors;
- Define helping relationship;
- Describe the three types of reflective listening;
- Demonstrate basic competence in reflective listening;
- Describe and demonstrate asking open-ended questions, affirming, summarizing, and rolling with resistance;
- Identify at least two effective counseling strategies for each stage of change;
- Demonstrate basic competence in three types of skills-based counseling:
 - Relapse prevention
 - Problem-solving
 - Goal-setting;
- Describe at least two basic issues or tasks for each typical group phase; and
- Demonstrate basic competence in group facilitation.

Training materials

Training materials include:

- This *Participant Manual*; and
- A notebook.

Each module of your *Participant Manual* includes:

- Training goals and learning objectives for the module;
- A timeline;
- PowerPoint slides printed three to a page spread with space for you to write notes;
- Resource Pages containing additional information or exercise instructions and materials; and
- A module summary.

The *Participant Manual* also has a glossary (Appendix A), a list of resources (Appendix B), and a list of people who are given special acknowledgment (Appendix C).

Your trainers will give you a notebook to use as your personal journal. You can use this journal in a number of ways. You can note:

- Topics you would like to read more about;
- A principle you would like to think more about;
- A technique you would like to try;
- Ways you might be able to add some of the things you're learning to your practice; and
- Possible barriers to using new knowledge.

Your trainers will also ask you to complete short writing assignments.

TAP 21 was developed in the United States to provide a common foundation on which to base training and certification of addiction professionals. The publication addresses these questions:

- What professional standards should guide counselors working with people with SUDs?
- What is an appropriate scope of practice for the field of SUD counseling?
- Which competencies are associated with positive treatment outcomes?
- What knowledge, skills, and attitudes should all SUD treatment professionals have in common?

TAP 21 can serve as a useful reference for you. Keep in mind, however, that it takes time and experience to develop counseling competence. TAP 21 represents an ideal set of goals, not a starting point. Don't get overwhelmed! You'll get there.

Getting the Most From Your Training Experience

To get the most from your training experience:

- If you have a supervisor, speak to him or her before the training begins. Find out what his or her expectations are for you.
- Think about what you want to learn from each module.
- Come to each session prepared; review the manual pages for the modules to be presented.
- Be an active participant. Participate in the exercises, ask questions, write in your journal, and think about what additional information you want.
- Speak to your supervisor (or co-workers, if you have no supervisor) after the training. Talk about what you learned to be sure you understand how the information relates to your job.
- Discuss with your supervisor or co-workers ways that you can put your learning into practice, and continue to follow up on your progress.
- **Have fun!**

U.S. DEPARTMENT OF STATE MODULE 0



Congratulations!

“

As a participant in this training, you are part of a rapidly growing global community of substance use professionals

”



U.S. DEPARTMENT of STATE

0.2

MODULE - 0

How is this global community of substance use professionals expanding?

In the last decade, a growing number of people are:

- ✓ being trained
- ✓ being credentialed
- ✓ studying at universities with specialized addiction programs
- ✓ operating in the context of a larger drug control system
- ✓ adhering to science and research-based approaches
- ✓ joining professional substance use associations
- ✓ networking through professional associations



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0.3

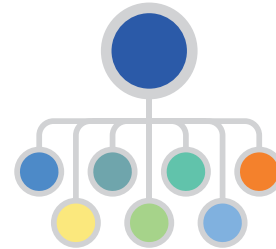
MODULE - 0

Who are the members of this global community of substance use professionals?



Individuals working worldwide in the substance use prevention and treatment fields in government, non-governmental organizations, civil society, and the private sector

Organizations that act as portals or “doorways” for individuals to join the global community



U.S. DEPARTMENT of STATE

0.4

MODULE - 0



ISSUP stands for the International Society of Substance Use Professionals

- ✓ ISSUP was launched by INL in 2015 as a global, not for profit, non-governmental organization to professionalize the global prevention and treatment workforce.
- ✓ ISSUP provides members with opportunities to share knowledge, exchange experiences, and stay abreast with current research in the field

Cont.



U.S. DEPARTMENT of STATE

0.5

MODULE - 0

ISSUP stands for the International Society of Substance Use Professionals

- ✓ There are more than 10,000 ISSUP members worldwide
- ✓ Join one of ISSUPs four levels of membership for free at: www.issup.net
- ✓ You can earn credit for this and other courses with ISSUP



U.S. DEPARTMENT of STATE

0.6

MODULE - 0



ICUDDR stands for the International Consortium of Universities for Drug Demand Reduction

- ✓ Global consortium of universities to promote academic programs that focus on science-based prevention and treatment
- ✓ Collaborative forum for individuals and organizations to support and share curricula, particularly this Universal Curriculum series, and experiences in the teaching and training of prevention and treatment knowledge

Cont.



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0.7

MODULE - 0

ICUDDR stands for the International Consortium of Universities for Drug Demand Reduction



Learn about specialized addiction programs at universities worldwide at www.icuddr.com



U.S. DEPARTMENT of STATE

0.8

MODULE - 0



GCCC stands for the Global Centre for Credentialing and Certification of Addiction Professionals

- ✓ The hours that you put into this training can be logged at GCCC and qualify you for exams and professional credentials
- ✓ GCCC credentials will help accelerate your career by indicating your passion and commitment to high standards

Cont.



U.S. DEPARTMENT of STATE

0.9

MODULE - 0

GCCC stands for the Global Centre for Credentialing and Certification of Addiction Professionals



Learn about how to apply the latest in research-based prevention and treatment at: www.globalccc.org



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0.10

MODULE - 0



Who funds and supports this global community of substance use professionals?

The U.S. Department of State's Bureau of International Narcotics and Law Enforcement Affairs (INL) which is funded by the U.S. taxpayer



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0.11

MODULE - 0

Where does this global community of substance use professionals meet?

- ✓ Digitally- through ISSUP and its networks and
- ✓ Face to face – through trainings, on university campus settings, and at conferences held at the global, national regional and local levels



U.S. DEPARTMENT of STATE

0.12

MODULE - 0

How does this global community of substance use professionals operate?

In the context of a larger international drug control environment that includes:

- United Nation's three international Drug Control Treaties or "Conventions"
- Commission on Narcotic Drugs (CND)
- International Narcotics Control Board (INCB)



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0.13

MODULE - 0

What are the key international organizations which operate in the context of this larger drug control environment?



DAP
Drug Advisory Program

The Colombo Plan Drug Advisory Program (DAP)



Inter-American Drug Abuse Control Commission

The Inter-American Drug Abuse Control Commission (CICAD) of the Organization of American States (OAS)



AFRICAN UNION

The African Union Commission (AUC)



UNODC

The United Nations Office on Drugs and Crime (UNODC)



World Health Organization

The World Health Organization (WHO)



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0.14

MODULE - 0

How can I participate in this global community of substance use professionals?

The easiest way is to become an active member of ISSUP!

- ✓ Register for free on the ISSUP website at www.issup.net
- ✓ Click on the “Apply for Membership” icon
- ✓ Select one of four levels of membership -all are free!
- ✓ Begin networking with others on an ongoing basis

It takes only a few minutes to register and you can immediately connect with over 10,000 ISSUP members worldwide!



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0.15

MODULE - 0

What are the benefits of being an active member of this global community of substance use professionals?

You can:

- ✓ Stay informed
- ✓ Implement best practices
- ✓ Access training and mentoring
- ✓ Turn training into credentials
- ✓ Access job postings
- ✓ Access up-to-date research
- ✓ Join a professional network
- ✓ Interact with other professional networks



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0.16

MODULE - 0

CALL TO ACTION

Next Steps

1. Join ISSUP at www.issup.net
2. Complete this training to earn credit
3. Send your credit hours to GCCC at www.globalccc.org

Participate in ISSUP

- Post on ISSUP: Find easy instructions for how to post on the ISSUP website
- Engage ISSUP's Networks: Connect with colleagues and broaden your impact



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0.17

MODULE - 0

MODULE 1

TRAINING INTRODUCTION

Content and timeline.	21
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Content and Timeline

Activity	Time
Ceremonial welcome	20 minutes
Trainer welcome, housekeeping, and ground rules	10 minutes
Partner exercise: Introductions	45 minutes
Presentation: Training materials	10 minutes
Presentation: Why this training?	15 minutes
<i>Break</i>	<i>15 minutes</i>
Large-group exercise: Training expectations	15 minutes
Exercise: Introduction to counselor characteristics and style	45 minutes
Presentation: Counselor characteristics and style	10 minutes
Reflective exercise: Counselor characteristics—Self-assessment	15 minutes

Module 1 Goals and Objectives

Training goals

- To create a positive learning community and environment;
- To give participants background information about why the training is being done;
- To give participants a summary of the overall training goals, objectives, and learning approach of the course; and
- To introduce participants to the concept and importance of counselor style and characteristics of effective counselors.

Learning objectives

Participants who complete Module 1 will be able to:

- Explain the overall training goals and at least four objectives of the 5-day training;
- State at least one personal learning goal;
- Describe the concept and importance of counselor style; and
- List at least five characteristics of effective counselors.



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Treatment of Substance Use Disorders

The Universal Treatment Curriculum for Substance Use Disorders (UTC)

UTC 4

Basic Counseling Skills
for Addiction Professionals



MODULE 1—TRAINING INTRODUCTION



DAP
Drug Advisory Programme

Module 1 Learning Objectives

- Explain the overall training goals and at least 4 objectives of the 5-day training
- State at least 1 personal learning goal
- Describe the concept and importance of counselor style
- List at least 5 characteristics of effective counselors

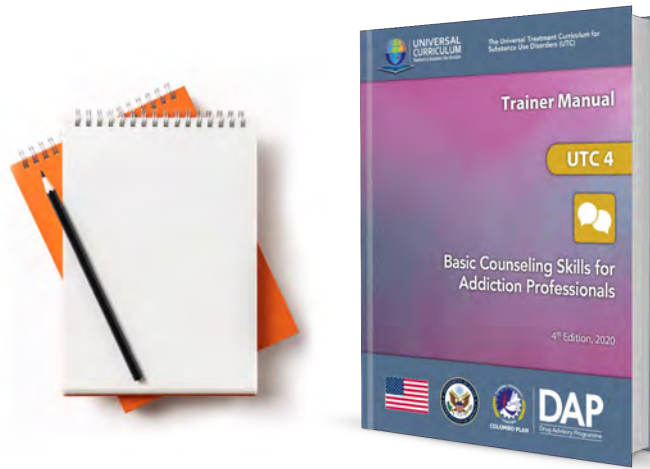
1.2

Exercise: Introductions

- What is your name?
- In what towns do you live and work?
- What is your job title?
- What does your job involve?
- How did you become interested in the counseling profession?

1.3

Training Materials



1.4

The Global Problem

- Over the period of 2009-2018, the estimated number of past year users of any drug was estimated to be 269 million.



Source: UNODC (2020). World Drug Report 2020. New York: United Nations.

1.5

The Global Problem

- 35.6 million suffers from drug use disorders
- People who suffer from drug use disorders/people with drug use disorders
 - ▣ Subset of people who use drugs
 - ▣ Need treatment, health and social care, and rehabilitation

Source: UNODC (2020). World Drug Report 2020. New York: United Nations.

1.6

Diagnostic and Statistical Manual- 5 (DSM-5)

- Published by the American Psychiatric Association
- Provides standards criteria for the classification of mental disorders
- Substance Use Disorder (SUD) is defined as a problematic pattern of substance use leading to clinically significant impairment in daily life or distress
- Level of severity is measured on a continuum from mild to severe

■ Source: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author

1.7

International Classification of Diseases (ICD-11)

- Published by WHO and covers health as a whole
- Covers more types of substances than ICD 10
- Patterns of psychoactive substance use are labelled -
 - Single episode of harmful use of a psychoactive substance
 - Harmful pattern of use – if the pattern is causing damage to health (physical or mental)
 - Dependence - if there is compulsion to use drugs and physical signs of a withdrawal state upon abstinence is present
 - Intoxication – that develops during or shortly after the consumption
 - Withdrawal – occurs upon cessation or reduction of use

Source: ICD-11 : International Classification of Disease for Mortality and Morbidity Statistics. (Eleventh Revision ed.): World Health Organisation

1.8

The Global Problem

- 11.3 million people injected drugs in 2018
- On average about 1.4 million of people who inject drugs are living with HIV
- About 5.5 million people who inject drugs are infected with hepatitis C while 940,000 are infected with hepatitis B

Source: UNODC (2020). World Drug Report 2020. New York: United Nations.

1.9

The Global Problem

- Global consequences of SUDs are far-reaching and include:
 - ▣ Higher rates of hepatitis and tuberculosis
 - ▣ Lost productivity
 - ▣ Injuries and deaths from automobile and other accidents
 - ▣ Overdose deaths
 - ▣ Suicides
 - ▣ Violence

1.10

The Global Problem

- “There continues to be an enormous unmet need for drug use prevention, treatment, care and support, particularly in developing countries.”

Yuri Fedotov, Executive Director,
UNODC (2010 to 2019)

Source: UNODC. (2011). *World drug report 2011* (p. 9). New York: United Nations.

1.11

Training Series Goals

- Building international treatment capacity through:
 - ▣ Training
 - ▣ Professionalizing
 - ▣ Expanding the workforce

1.12

Courses in the Series

- UTC 1: *Introduction to the Science of Addiction* (3 days)
 - ▣ Foundational, not how-to or skills-based course
 - ▣ Overview of the physiology of addiction as a brain disease and the pharmacology of psychoactive substances

1.13

Courses in the Series

- UTC 2: *Treatment for Substance Use Disorders—The Continuum of Care for Addiction Professionals* (5 days)
 - ▣ Builds the foundation for understanding SUD treatment and the continuum of care
 - ▣ Provides an overview of recovery and recovery management, stages of change, components of SUD treatment and evidence-based practices

1.14

Courses in the Series

- UTC 3: *Common Co-Occurring Mental and Medical Disorders—An Overview for Addiction Professionals* (3 days)
 - ▣ Provides an overview of co-occurring disorders (COD), its relationship to one another
 - ▣ Discusses COD treatment and related issues as well as mental and medical disorders that commonly co-occur with SUD

1.15

Courses in the Series

- UTC 5: *Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals* (5 days)
 - ▣ Provides an overview of effective, integrated screening, assessment and treatment planning in SUD treatment;
 - ▣ Introduces the use of valid screening and assessment tools
 - ▣ Highlights the importance of documentation in the process

1.16

Courses in the Series

- UTC 6: *Case Management for Addiction Professionals* (2 days)
 - ▣ Provides understanding of case management in SUD treatment
 - ▣ Describes case management functions (planning, linkage, monitoring, advocacy, consultation, and collaboration)
 - ▣ Provides opportunities to practice case management

1.17

Courses in the Series

■ UTC 7: *Crisis Intervention for Addiction Professionals* (2 days)

- ▣ Develops an understanding of crisis
- ▣ Provides guidelines for crisis management, managing suicide risk, and avoiding your own crisis (counselor self-care)

1.18

Courses in the Series

- UTC 8: *Ethics for Addiction Professionals* (4 days)
 - ▣ Develops an understanding of ethics in SUD treatment practice
 - ▣ Provides an overview of the standards of professional conduct as defined in the Code of Ethics
 - ▣ Introduces the ethical decision-making Model and provides opportunities for practice

1.19

Course 4 Learning Objectives

- Describe the concept and importance of counselor style
- List at least 5 characteristics of effective counselors
- Define the helping relationship
- Describe 3 types of reflective listening
- Demonstrate basic competence in reflective listening

1.20

Course 4 Learning Objectives (continued)

- Describe and demonstrate asking open-ended questions, affirming, summarizing, and rolling with resistance
- Identify at least 2 effective counseling strategies for each stage of change
- Demonstrate basic competence in 3 types of skills-based counseling
- Describe basic principles of group counseling
- Describe at least 2 basic issues or tasks for each typical group phase

1.21

Break

15 minutes

1.22

Large-Group Exercise: Training Expectations

- Write 2 training expectations on your index card

1.23

Guided Imagery: Special Person



1.24

Counselor Characteristics and Style

- The characteristics of counselors themselves have an enormous effect on the treatment process, especially in terms of the counselor–client relationship



1.25

Counselor Characteristics and Style

- Clients who had the best treatment outcomes had counselors who had the best interpersonal skills, were the least confrontational, and were the most empathic

Source: Finney, J. W., Wilbourne, P. L., & Moos, R. H. (2007). Psychosocial treatment for substance use disorders. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (3rd ed., pp. 179–202). New York: Oxford University Press.

1.26

Desirable Interpersonal Skills

- Personal ability
- Warmth and empathy
- Genuineness
- Positive regard and respect
- Immediacy
- Cultural competence



1.27

Personal Ability

- Psychologically healthy
- Comfortable talking about a wide range of issues
- Self-aware
- Ability to set personal and professional boundaries
- High level of knowledge and competence regarding SUDs

1.28

Genuineness

- Strong interest in helping others
- Can be in a relationship without playing a role
- Sincere desire to understand others
- Honest in his or her interactions with others

1.29

Immediacy

- Attends to and shares what is happening within the professional relationship
- Focuses on the issue at hand
- Attends to what is important to the client
- Adjusts easily and well to changing topics when necessary

1.30

Warmth and Empathy

- Genuinely friendly
- Demonstrates “humanness”
- Accepts the client where the client is
- Shows understanding

1.31

Empathy

- Is the ability to understand the sources of and reasons for client’s perspective, thoughts and actions, and the ability to convey accurately your understanding back to the client, usually through reflections

Source: Miller, W.R. and Rollnick, S. (2012). Helping People Change, 3rd Edition (Applications of Motivational Interviewing) © 2013 The Guilford Press, N.Y. USA 10012

1.32

Positive Regard and Respect

- Positive regard is an attitude of respect –
Respect is the action
- An attitude of regard involves suspending
judgment, being open-minded, and being
objective
- Being respectful means demonstrating sensitivity
and being trustworthy
- Linked to belief that people can and will solve
their problems

1.33

Relevant Concepts: Cultural Competence

- Cultural competence “refers to the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services” Source (Substance Abuse and Mental Health Services Administration, 2014, p. xv).
- SAMHSA, USA, published a guiding document for developing cultural competencies among professionals who provide treatment to people with substance use disorders

source: (Substance Abuse and Mental Health Services Administration, SAMHSA (2014). Improving Cultural Competence, TIP 59. Available at <https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849>)

1.34

Why developing skills in Cultural Competence is important for substance use treatment?

- Culturally responsive skills can improve the persons' engagement in the services, therapeutic relationships between the person and providers, and treatment retention and outcomes. Cultural competence is an essential ingredient in reducing health disparities arising from the care provided by the health system itself.

(Ref. Substance Abuse and Mental Health Services Administration, SAMHSA (2014). Improving Cultural Competence, TIP 59. Available at <https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849>)

1.35

Cultural Awareness

- It is the awareness and reflection of counselors regarding their own cultural background and how it can affect the relationship with the persons served.
- With cultural awareness, counselor explore how their own beliefs, experiences and biases affect their definitions of normal and abnormal behavior.
- It implies that professionals are aware of their own assumptions and prejudices regarding other cultural groups (e.g. LGBT culture); and make an effort to understand how these factors affect their ability to provide culturally responsive services to people in treatment.
- Cultural awareness is the first step toward becoming a culturally competent counselor.

1.36

Reflective Exercise: Self-Assessment

- What strengths do I bring to my work as a counselor?
- What areas might I need to work on?

1.37

Importance of Inclusive Language

Guidelines for the use of gender-inclusive language

USEFUL STRATEGIES:.

1. Avoid discriminatory expressions
2. Make gender visible when it is relevant for communication
3. Do not make gender visible when it is not relevant for communication

Resource page related to inclusive language, UN.
Review Annex: Part 4 from "ENG-Gender Update UTC 2 and 4 done.docx

1.38

Resource Page 1.1: The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) Criteria for Substance Use Disorder¹

Substance Use Disorder (SUD) is a problematic pattern of use of an intoxicating substance leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. The substance is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful effort to cut down or control use of the substance.
3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
4. Craving, or a strong desire or urge to use the substance.
5. Recurrent use of the substance resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use.
7. Important social, occupational, or recreational activities are given up or reduced because of use of the substance.
8. Recurrent use of the substance in situations in which it is physically hazardous.
9. Use of the substance is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
 - a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
 - b. A markedly diminished effect with continued use of the same amount of the substance.
11. Withdrawal, as manifested by either:
 - a. The characteristic withdrawal syndrome for the substance (excludes Phencyclidine, Other Hallucinogens, and Inhalants).
 - b. The substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

Note: This criterion is not considered met for those taking opioids, sedatives, hypnotics or anxiolytics, or stimulant medications solely under appropriate medical supervision.

¹ <https://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics>

Resource Page 1.2 : ICD-11 Classification of Mental and Behaviour Disorder

Disorders due to substance use include single episodes of harmful substance use, substance use disorders (harmful substance use and substance dependence), and substance-induced disorders such as substance intoxication, substance withdrawal and substance-induced mental disorders, sexual dysfunctions and sleep-wake disorders.

Disorders due to use of substances

Disorders due to use of substance are characterised by the pattern and consequences of substance use. In addition to Substance intoxication, Substance has dependence-inducing properties, resulting in Substance dependence in some people and Substance withdrawal when use is reduced or discontinued. Substance is implicated in a wide range of harms affecting most organs and systems of the body, which may be classified as Single episode of harmful use and Harmful pattern of use. Harm to others resulting from behaviour during Substance intoxication is included in the definitions of Harmful use of substance. Several substance-induced mental disorders and substance-related forms of neurocognitive impairment are recognised.

Single episode of harmful use of substances

A single episode of use of substance that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following:

- (1) behaviour related to intoxication;
- (2) direct or secondary toxic effects on body organs and systems; or
- (3) a harmful route of administration.

Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behavior due to substance intoxication on the part of the person to whom the diagnosis of single episode of harmful use applies.

This diagnosis should not be made if the harm is attributed to a known pattern of substance use.

Exclusion

- Harmful pattern of use of substance
- Substance Dependence

¹ ICD-11 : International Classification of Disease for Mortality and Morbidity Statistics. (Eleventh Revision ed.): World Health Organisation.

Harmful pattern of use of substances

A pattern of psychoactive substance use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of psychoactive substance use is evident over a period of at least 12 months if substance use is episodic or at least one month if use is continuous. Harm to health of the individual occurs due to one or more of the following:

- (1) behaviour related to intoxication;
- (2) direct or secondary toxic effects on body organs and systems; or
- (3) a harmful route of administration.

Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to psychoactive substance intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of psychoactive substance applies.

Exclusion

- Substance Dependence
- Episode of Harmful Use of Substance

Substance Dependence

Dependence on a psychoactive substance is a disorder of regulation of psychoactive substance use arising from repeated or continuous use of psychoactive substance. The characteristic feature is:

- a strong internal drive to use the psychoactive substance, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use the psychoactive substance.
- physiological features of dependence may also be present, including tolerance to the effects of the psychoactive substance, withdrawal symptoms following cessation or reduction in use of the psychoactive substance, or repeated use of psychoactive substance or pharmacologically similar substances to prevent or alleviate withdrawal symptoms.

The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if psychoactive substance use is continuous (daily or almost daily) for at least 1 month.

Exclusion

- Episode of Harmful Use of Substance
- Harmful pattern of use of substance

Intoxication

Intoxication is a clinically significant transient condition that develops during or shortly after the consumption of a psychoactive substance that is characterized by disturbances in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of psychoactive substance and their intensity is closely related to the amount consumed. Presenting features may include impaired attention, inappropriate or aggressive behaviour, lability of mood, impaired judgment, poor coordination, unsteady gait, and slurred speech. At more severe levels of intoxication, stupor or coma may occur.

Withdrawal

Withdrawal is a clinically significant cluster of symptoms, behaviours and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of alcohol in individuals who have developed dependence or have used psychoactive substances for a prolonged period or in large amounts. Presenting features of withdrawal may include autonomic hyperactivity, increased hand tremor, nausea, retching or vomiting, insomnia, anxiety, psychomotor agitation, transient visual, tactile or auditory hallucinations, and distractibility. Less commonly, the withdrawal state is complicated by seizures. The withdrawal state may progress to a very severe form of delirium characterized by confusion and disorientation, delusions, and prolonged visual, tactile or auditory hallucinations.

Note: The detailed diagnostic criteria can be accessed at the WHO website.

Note: At the time of the updating of this Course, the ICD-11 was in the final stages of revision and not yet formally released. However, INL and the Treatment Expert Advisory Group, in the interest of providing UC trainees with the latest and most current guidance on substance use disorders, requested inclusion of the ICD-11 language, 'as is.'

Resource Page 1.3: The Universal Treatment Curriculum for Substance Use Disorders (UTC) Basic Level Training Series

- UTC 1: *Introduction to the Science of Addiction*
- UTC 2: *Treatment for Substance Use Disorders—The Continuum of Care for Addiction Professionals*
- UTC 3: *Common Co-Occurring Mental and Medical Disorders—An Overview for Addiction Professionals*
- UTC 4: *Basic Counseling Skills for Addiction Professionals (this course)*
- UTC 5: *Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals*
- UTC 6: *Case Management for Addiction Professionals*
- UTC 7: *Crisis Intervention for Addiction Professionals*
- UTC 8: *Ethics for Addiction Professionals*

Module 1—Training Introduction, Summary

The global problem

- Psychoactive substance use continues to be a global problem. A survey done by the United Nations Office on Drugs and Crime (or UNODC) found that, in 2018, 269 million people between ages 15 and 64 used illicit substances at least once in 2018¹.
- Illicit substances in the survey included opioids, cannabis, cocaine, other amphetamine-type stimulants, hallucinogens, and ecstasy, among others.
- A significant number of people who use psychoactive substances develop SUDs.
- The UNODC report estimates a total of 35.6 million people between ages 15 and 64 suffer from drug use disorders. People who suffer from drug use disorders or people with drug use disorders are those subsets of people who use drugs and are in need of treatment, health and social care, and rehabilitation.
- Substance use disorder is a general term used to describe a range of problems associated with substance use (including illicit drugs and misuse of prescribed medications).
- There are two classification systems used in the diagnosis of drug use disorders or SUDs, the Diagnostic Statistical Manual (DSM) and the International Classification of Diseases (ICD).
- The Diagnostic Statistical Manual (DSM), published by the American Psychiatric Association, offers a common language and standards criteria for the classification of mental disorders.
- In 2013, the APA updated the DSM, replacing the categories of substance abuse and substance dependence with a single category: substance use disorder (SUD).
- SUD is defined as a problematic pattern of substance use leading to clinically significant impairment or distress as manifested by at least two of the 11 criteria occurring in a 12-month period. The level of severity is measured on a continuum from mild to severe.
- The symptoms associated with SUD fall into four major groupings: impaired control; social impairment; risky use; and pharmacological criteria (i.e., tolerance and withdrawal).
- Another classification system is the International Classification of Diseases (ICD), published by the World Health Organization.
- It is distinguished from the DSM in that it covers health as a whole. Under ICD-11, patterns of psychoactive substance use are labelled,
 - Single episode of harmful use of a psychoactive substance - refers to a single episode of use of psychoactive substance that has caused damage to a person's physical or mental health or has resulted in behavior leading to harm to the health of others.

- Harmful use - if the pattern is causing damage to health. The damage may be physical (as in the case of hepatitis from self-administration of injected drugs) or mental (e.g., episodes of depressive disorder secondary to heavy consumption of alcohol), and
 - Dependence - if the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviors that once had greater value. There is compulsion to use drugs and physical signs of a withdrawal state upon abstinence.
 - Intoxication – a clinically significant transient condition that develops during or shortly after the consumption characterized by disturbances in consciousness, cognition, perception, affect behavior or coordination.
 - Withdrawal – is a clinically significant cluster of symptoms, behaviors and/or physiological features, varying in degree of severity and duration, which occurs upon cessation or reduction of use of alcohol in individuals who have developed dependence or have used psychoactive substances for a prolonged period or in large amounts. Presenting features of withdrawal may include autonomic hyperactivity, increased hand tremor, nausea, retching or vomiting, insomnia, anxiety, psychomotor agitation, transient visual, tactile or auditory hallucinations, and distractibility.
- The UNODC report estimates a total of 35.6 million people between ages 15 and 64 suffer from drug use disorders. People who suffer from drug use disorders or people with drug use disorders are those subsets of people who use drugs and are in need of treatment, health and social care, and rehabilitation.
 - The U. N Survey also found that:¹
 - 11.3 million people injected drugs in 2018
 - About 12.6 percent (1.4 million) of those who inject drugs are HIV positive.
 - About 48.5 percent (5.5 million) of those who inject drugs are infected with Hepatitis C.
 - Global consequences of SUDs are far-reaching and include, for example:
 - Higher rates of HIV/AIDS, hepatitis and tuberculosis.
 - Lost productivity;
 - Injuries and death due to automobile and other accidents;
 - Overdose hospitalizations and deaths;
 - Suicides; and
 - Violence.
 - The numbers are significant. Yuri Fedotov, Executive Director of UNODC (2010 to 2019), notes that “there continues to be an enormous unmet need for drug use prevention, treatment, care and support, particularly in developing countries.” There are a number of reasons for this, but one reason is a lack of adequate treatment capacity.

The training series

- This course is part of a training series developed through funding from the U.S. Department of State to The Colombo Plan.
- The overall goal of the training series is to reduce the health, social, and economic problems associated with SUDs by building international treatment capacity through training, professionalizing, and expanding the global treatment workforce.
- The series prepares counselors for professional certification at the entry level by providing them with necessary information and with specific skills training. See You will find a list of the courses included in the training series on Resource Page 1.3 in your manuals.

Other Courses in the series

- Course 1: Introduction to the Science of Addiction is a 3-day course that presents a comprehensive overview of addiction, provides an understanding of the physiology of addiction as a brain disease, and describes the pharmacology of psychoactive substances.
- Course 2: Treatment for Substance Use Disorders—The Continuum of Care for Addiction Professionals is a 5-day foundational course. By this we mean that it provides a necessary foundation for learning about SUD treatment. It is not a how- to or skills-based course, but it provides a context for the skills-based courses later in the series. Course 2 provides an overview of recovery, recovery management, stages of change, principles of effective treatment, components of treatment, factors affecting treatment outcomes, and evidence-based practices, including couples and family counseling.
- Course 3: Common Co-Occurring Mental and Medical Disorders—An Overview for Addiction Professionals is a 3-day course. It is also a foundational course and provides an overview of the relationship of co-occurring disorders to one another and to SUD related treatment issues. It outlines brief descriptions of the most commonly cooccurring mental and medical disorders with SUD.
- Course 4: Basic Counseling Skills for Addiction Professionals is a 5-day skills-based course. It provides an overview of the helping relationship. It also provides opportunities to learn and practice core counseling and basic motivational interviewing skills which are essential at every stage of treatment and in every type of counseling situation, including working with families. Basic group (for clients and family members) counseling and psychoeducational group skills also are covered in the course.
- Course 5: Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals is 5-day skills-based course that teaches effective, integrated assessment and treatment/service planning. It also addresses the importance of documentation in the treatment process.

¹United Nations Office on Drugs and Crime, World Drug Report 2020

²UNODC. (2011). World drug report 2011 (p.9). New York: United Nations.

- Course 6: Case Management for Addiction Professionals is a 2-day foundational and skills-based course that provides an overview of case management in SUD treatment and provides skills practice in case management functions such as planning, linkage, monitoring, advocacy, consultation, and collaboration.
- Course 7: Crisis Intervention for Addiction Professionals, a 2-day course, addresses the concept of crisis as a part of life and provides guidelines for and practice in crisis management, including managing suicide risk. It also addresses ways counselors can avoid personal crisis situations by providing information and exercises about counselor self-care.
- UTC 8: Ethics for Addiction Professionals is a 4-day course that aims to develop an understanding of ethics in SUD treatment and provides an overview of professional conduct as defined in the Code of Ethics. It provides the opportunity to learn and practice the process of ethical decision making. The course also addresses the importance of supervision as part of ethical practice.

Counselor Characteristics and Style

- It's important to know that the characteristics of counselors themselves have an enormous effect on the treatment process and its subsequent success or failure, especially in terms of the counselor–client relationship.
- A client's motivation, engagement in treatment, and treatment outcomes can be affected by a counselor's personal characteristics and style of interaction as much as—or even more than—client characteristics and the counselor's specific techniques.
- A review of the literature on counselor characteristics related to SUD treatment effectiveness found that clients who had the best treatment outcomes had counselors who had the best interpersonal skills, were the least confrontational, and were the most empathic.³

Desirable Interpersonal Skills

- Other research has identified the most desirable interpersonal skills for a person working with people with SUDs:
 - Personal ability;
 - Genuineness;
 - Immediacy;
 - Warmth and empathy; and
 - Positive regard and respect.
 - Cultural Competence

■ *Personal ability we mean that the counselor:*

- Is psychologically healthy (This does not mean that the counselor has no personal problems! It just means that he or she has adequate coping and living skills.).
- Is comfortable talking about a wide range of issues;
- Is self-aware;
- Has the ability to set personal and professional boundaries; and
- Has a high level of knowledge and competence regarding SUDs.

■ *Genuineness means that the counselor:*

- Has a strong interest in helping others;
- Can be himself or herself in a relationship without playing a role;
- Has a sincere desire to understand others; and
- Is honest in his or her interactions with others.

■ *Immediacy means that the counselor:*

- Is able to attend to and share what is happening within the professional relationship;
- Can stay focused on the issue at hand;
- Can attend to what is important to the client; and
- Is able to adjust easily and well to changing topics when necessary.

■ *Warmth and empathy mean that the counselor:*

- Is genuinely friendly;
- Demonstrates “humanness”;
- Accepts the client where the client is; and
- Shows understanding.

■ The terms empathy and sympathy are commonly used interchangeably, but they do not mean the same thing. When you are sympathetic, you feel for people; you feel sorry for them or pity them, but you don’t necessarily understand what they’re feeling.

■ Empathy is a more active process. It is the ability to understand the sources of and reasons for client’s perspective, thoughts and actions, and the ability to convey accurately your understanding back to the client, usually through reflections.

³Finney, J. W., Wilbourne, P. L., & Moos, R. H. (2007). Psychosocial treatment for substance use disorders. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (3rd ed., pp. 179–202). New York: Oxford University

- To be empathic is to make an effort to understand another person's frame of reference and to communicate that understanding to the person in a non-judgmental manner. It is often characterized as the ability to "put oneself into another's shoes", or in some way experience the outlook or emotions of another being within oneself.
- Communicating empathy involves using a set of skills that can be learned; we'll be talking about and practicing these skills (like reflective listening) later in the training.
- *Positive regard and respect:*
 - Positive regard is the attitude of respect; respect is the action. Respect is demonstrated in the way you treat your clients.
 - An attitude of positive regard involves suspending judgment about a person are being open-minded and objective.
 - Being respectful means being sensitive to the other person's situation and life experiences. It also can mean being trustworthy.
 - Positive regard and respect are linked to a belief that people can and will solve their problems.
- *Cultural Competence*
 - SAMHSA has defined Cultural Competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services" (Substance Abuse and Mental Health Services Administration, 2014, p. xv). This institution published a guiding document, the Treatment Improvement Protocol, TIP 59, to improve the development of cultural competence among professionals working in the mental health field.
 - The recognition of cultural diversity poses a challenge to intervention, not only because it reveals the importance of culture in the therapeutic processes, but also because of the almost impossible task of getting to know this culture in depth. To address this challenge, the development of cultural competences in technicians and professionals - and in the care system - seems to be an appropriate response, under the assumption that there will be an ongoing improvement in the recognition of the cultural dimensions of interventions.
 - Culturally responsive skills can improve the persons' engagement in the services, therapeutic relationships between the person and providers, and treatment retention and outcomes. Cultural competence is an essential ingredient in reducing health disparities arising from the care provided by the health system itself.
 - Cultural awareness is the reflection of counselors regarding their own cultural background and how it can affect the relationship with the persons served.
 - With cultural awareness, counselor explore how their own beliefs, experiences are biases affect their definitions of normal and abnormal behavior.

- It implies that professionals are aware of their own assumptions and prejudices regarding other cultural groups (e.g., LGBT culture); and make an effort to understand how these factors affect their ability to provide culturally responsive services to people in treatment.
 - Cultural awareness is the first step toward becoming a culturally competent counselor.
- Useful Strategies the use of gender-inclusive language:
- Avoid discriminatory expressions
 - Make gender visible when it is relevant for communication
 - Do not make gender visible when it is not relevant for communication

⁴source: (Substance Abuse and Mental Health Services Administration, SAMHSA (2014). Improving Cultural Competence, TIP 59. Available at <https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849>)

MODULE 2

THE HELPING RELATIONSHIP

Content and timeline.	63
Training goals and learning objectives	63
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Content and Timeline	
Activity	Time
Introduction to Module 2	10 minutes
Presentation: Introduction to the helping relationship	10 minutes
Presentation: Counselor self-disclosure	10 minutes
Small-group exercise: Counselor self-disclosure— Part 1, preparation	15 minutes
<i>Lunch</i>	<i>60 minutes</i>
Small-group exercise: Counselor self-disclosure— Part 2, presentation	35 minutes
Presentation: Dual relationships	10 minutes
Small-group exercise: Dual relationships	20 minutes
Presentation: Transference and counter-transference	20 minutes
<i>Break</i>	<i>15 minutes</i>
Interactive presentation: Non-verbal communication	35 minutes
Reflective exercise: The helping relationship	15 minutes
Day 1 learning assessment and wrap-up	15 minutes

Module 2 Goals and Objectives

Training goals

- To provide an overview of the helping relationship concept; and
- To provide an opportunity for participants to consider the complexity of counselor self-disclosure and other issues inherent to the helping relationship.

Learning objectives

Participants who complete Module 2 will be able to:

- Define helping relationship;
- Discuss the potential benefits and problems of counselor self-disclosure;
- Define and provide at least three examples of dual relationships;
- Define transference and counter-transference; and
- Discuss at least three elements of non-verbal communication.



UNIVERSAL
CURRICULUM
Treatment of Substance Use Disorders

The Universal Treatment Curriculum for Substance Use Disorders (UTC)

UTC 4

Basic Counseling Skills
for Addiction Professionals



MODULE 2—THE HELPING RELATIONSHIP



DAP
Drug Advisory Programme

The Helping (or Therapeutic) Relationship

- The relationship between a counselor and a client and the means by which the professional hopes to engage with, support, and facilitate change in a client

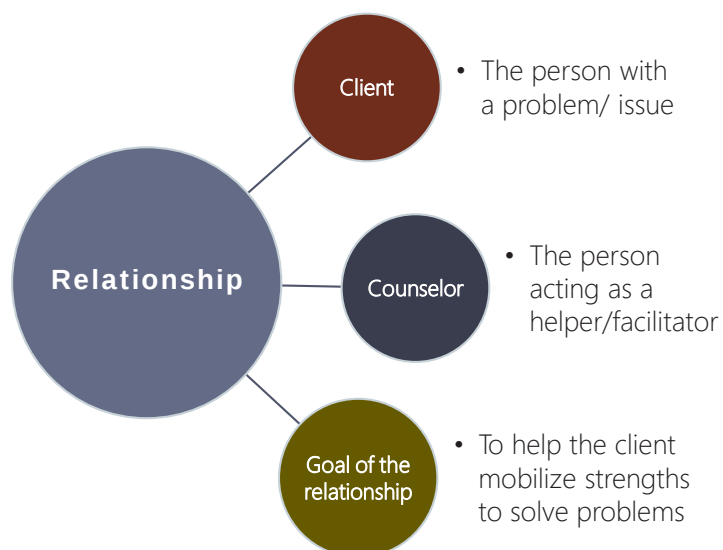
2.2

Module 2 Learning Objectives

- Define helping relationship
- Discuss the potential benefits and problems of counselor self-disclosure
- Define and provide at least 3 examples of dual relationships
- Define transference and counter-transference
- Discuss at least 3 elements of non-verbal communication

2.3

The Helping Relationship



2.4

Counseling

■ A process of empowerment:

- Facilitate
- Teach
- Support



2.5

Empowerment

- Having the power, confidence, and skills to make healthy and productive choices and having a range of options from which to make these choices



2.6

Relationship Boundaries

- Set limits on behavior
- Help define us and our relationships
- Clarify expectations and give us rules about our roles
- Protect us and others



2.7

Counselor Self-Disclosure: Positive Aspects

- Reduces client feelings of being alone in a certain situation
- Promotes feelings of empathy in the counselor
- Increases the client's perception of the counselor as trustworthy
- Increases client self-disclosure
- A therapist can share the difficulties he/she has faced in dealing with anger management and how he/she coped with them. If well managed, it can make the person served feel understood and at the same time, modeling can make learning new skills easier. If poorly handled, it can make the person served feel inferior or think the therapist is boasting about.

2.8

Counselor Self-Disclosure: Positive Aspects (continued)

- Increases the client's expression of feelings and self-exploration
- Elicits new perceptions from the client
- Can be used to model new roles and behaviors

2.9

Counselor Self-Disclosure: Negative Aspects

- Can be seen as threatening and can blur relationship boundaries
- Counselor can be perceived as lacking discretion, being untrustworthy or self-preoccupied, and/or needing therapy

2.10

Counselor Self-Disclosure: Negative Aspects (continued)

- Can provide premature feedback about a client's attitude/behavior
- Can contribute to a client's feeling inferior or rejected
- Does not allow client to talk

2.11

Counselor Self-Disclosure

- Must be for the client's benefit, not for the counselor's needs or desires
- Counselor must be comfortable sharing
- Sharing one's own recovery with a client is not necessary
- The more a counselor talks, the less time is available for the client

Source: Lawson, G. W., Lawson, A. W., & Rivers, P. C. (2000). *Essentials of chemical dependency counseling* (3rd ed.) Rockville, MD: Aspen Publications.

2.12

Ask Yourself

- Do I feel *comfortable* telling this piece of information about myself to my client?
- Is it *safe* for me to reveal this information?
- Will this disclosure *benefit* my client?
- Can my client *use* this information to advance treatment?
- Will my client view this disclosure as *helpful*?

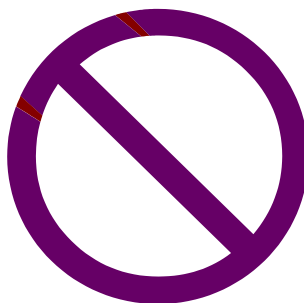


2.13

Disclosure?

- If the answer to *any* of these questions is no,

DO NOT DISCLOSE



2.14

Disclosure?

- The window for self-disclosure will open many times in the counseling relationship; there is no need to rush!
- For new counselors it is best to err on the side of *not* disclosing

2.15

Small-Group Exercise: Self-disclosure

- Open your piece of paper for your assignment: appropriate or inappropriate self-disclosure
- Do not tell the other groups which type you have!
- Develop a 2-minute skit of a counseling session in which the counselor self-discloses
- Assign someone to take notes, someone to be the “counselor,” and someone to be the “client”

2.16

Lunch

60 minutes

2.17

Small-Group Exercise: Self-disclosure

- Open your piece of paper for your assignment: appropriate or inappropriate self-disclosure
- Do not tell the other groups which type you have!
- Develop a 2-minute skit of a counseling session in which the counselor self-discloses
- Assign someone to take notes, someone to be the “counselor,” and someone to be the “client”

2.18

Dual Relationships

■ When a counselor serves both in the capacity of counselor and in at least one other role with the same client

■ Examples:

- ▣ Social
- ▣ Financial
- ▣ Professional



2.19

Dual Relationships

■ Networks of relationships are the nature of community



2.20

Managing Possible Dual Relationships

- Avoid when possible
- Minimize the involvement when avoidance is not possible
- Make conscious, respectful choices

2.21

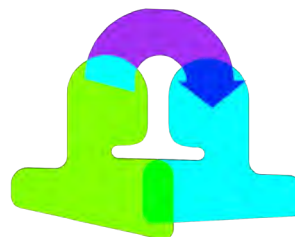
Small-Group Exercise: Dual Relationships

- Two groups: Rural and urban
- Select someone to take notes
- Discuss:
 - ▣ The types of dual relationships you have experienced, heard about, or think are likely to occur in your communities
 - ▣ How each situation might be avoided or minimized

2.22

Transference in Counseling: Definition

- A process in which a client transfers onto the counselor attitudes, feelings, and desires from other significant relationships
- Often happens unconsciously and can be based on childhood relationships



Source: Corey, G., Corey, M., & Callanan, P. (2011). *Issues and ethics in the helping professions*. Pacific Grove, CA: Brooks/Cole.

2.23

Transference

- Transference can distort how the client perceives and reacts to the counselor



2.24

Examples: Client Distortions of Counselor

- Client may see the counselor as being perfect in every way and see himself as “less than”
- Client may see the counselor as a nurturer and play a “helpless,” overly dependent role
- Client may see the counselor as an authority figure and assume the counselor is judging him/her

Source: Corey, G., Corey, M., & Callanan, P. (2011). *Issues and ethics in the helping professions*. Pacific Grove, CA: Brooks/Cole.

2.25

Transference

- A counselor can use transference to gain insight into the client’s personality and interactions with family members and peers
- If a counselor is not aware of the transference, his or her reaction to the behavior could be counter-therapeutic

2.26

Counter-Transference: Definition

- Counter-transference occurs when the counselor transfers onto a client feelings and attitudes about other people in his or her past or present personal life
- Counter-transference can also happen in response to a client's issue that also troubles the counselor

2.27

Examples: Counter-Transference

- Counselor is worried that the client will leave treatment if he/she confronts the client. He/she sees the premature termination of treatment as personal rejection
- A counselor is intimidated by the client's anger at him/her or others. When the client cancels a session, the counselor finds him/herself relieved
- The client has had a very difficult life. The counselor goes out of his/her way to be helpful to this client to the extent that he becomes dependent on the counselor.

Source: Corey, M.S. and Corey, G. (2011). *Becoming a helper*, Sixth Edition. Brooks/Cole, Cengage Learning, CA, USA

2.28

Counter-Transference

- Counter-transference is normal; all counselors experience it!
- The counselor just needs to recognize and effectively process it so that it does not negatively impact the client

2.29

Counter-Transference

■ To prevent counter-transference:

- ▣ Do your own emotional work
- ▣ Be aware
- ▣ Use supervision/consultation



Source: <https://ct.counseling.org/2013/09/attending-to-countertransference/>

2.30

Break

15 minutes

2.31

Non-verbal Communication

- Facial expressions, eye contact, gestures, posture, and position can “say” just as much as (in fact, more than) our words



2.32

Non-verbal Communication

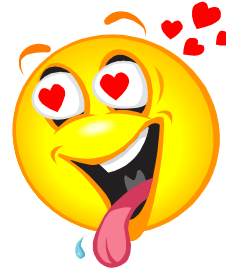
- Is largely unconscious
- Is learned at an early age from our families and culture
- Counselors must:
 - ▣ Attend to client's non-verbal cues
 - ▣ Be self-aware



2.33

Non-verbal Communication: Facial Expressions

- Facial expressions are universal



2.34

Culture-Based Non-verbal Communication

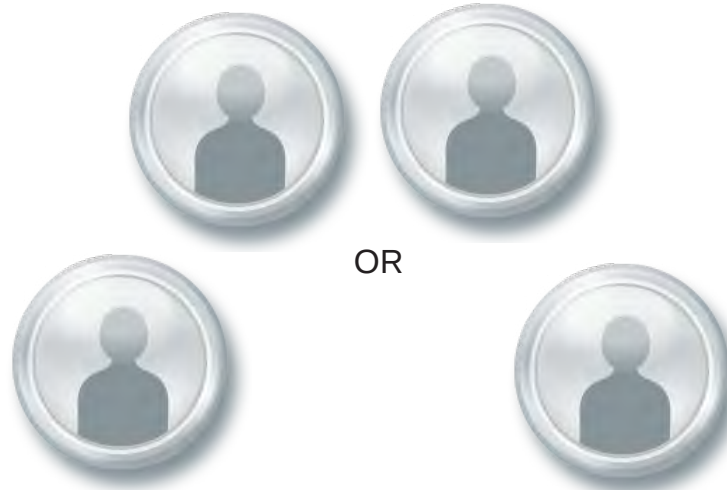
- Eye contact: A sign of interest and respect or intrusive, dominating, and disrespectful?
- Gestures: Expressive and the norm or intimidating?



2.35

Culture-Based Non-verbal Communication

■ Spatial position and touch



2.36

Touch

- For some people, a light touch on the hand or shoulder will feel comforting and caring; for others, it may feel like an invasion
- People who have been physically or sexually abused often have particularly strict personal space requirements
- People with certain mental illnesses may have either very strong or very weak personal space boundaries
- Be careful!

2.37

Other Non-verbal Communication

- Some non-verbal communication tends to be consistent across cultures:
 - ▣ Responses to anxiety
 - ▣ Signs of anger
 - ▣ Signs of interest

2.38

Reflective Exercise

- What did you hear that was new to you?
- How do you think it relates to your practice?



2.39

Resource Page 2.1: Tips for Successful Non-verbal Communication

- **Pay attention to inconsistencies.** Non-verbal communication should reinforce what is being said. If you get the feeling that someone isn't being honest or that something is "off," you may be picking up on a mismatch between verbal and non-verbal cues. Is the person is saying one thing, and their body language saying something else? For example, are they telling you yes while shaking their head no?
- **Look at non-verbal communication signals as a group.** Don't read too much into a single gesture or non-verbal cue. Consider all of the non-verbal signals you are sending and receiving, from eye contact to tone of voice and body language. Are your non-verbal cues consistent—or inconsistent—with what you are trying to communicate?
- **Take a time out if you're feeling overwhelmed by stress.** Stress compromises your ability to communicate. When you're stressed out, you're more likely to misread other people, send confusing or confrontational non-verbal signals, and lapse into unhealthy knee-jerk patterns of behavior. Take a moment to calm down before you jump back into the conversation. Once you've regained your emotional equilibrium, you'll be better equipped to deal with the situation in a positive way.
- **Culture and non verbal communication :** Non-verbal communication is different from person to person and especially from one culture to another. Cultural background defines their non-verbal communication as many forms of non-verbal communications like signs and signals are learned behavior. As there are differences in meanings of non-verbal communication, miscommunication can occur when inter-cultural people communicate. People can offend others without meaning to due to their cultural differences in non-verbal communication. Facial expressions are mostly similar in most cultures as many of them like smile and cry are innate.

Resource Page 2.2: Basic Principles for Working With Clients

Clients who use drugs or are in early recovery from drug use often do not trust people who say they want to help, particularly if they have been referred by someone else. Developing a relationship takes time and patience; several visits may be required before a client discusses drug use and other problems with you. Genuine interest in developing rapport and understanding drug use issues and the lives of clients will go a long way when working with clients.

There are six basic principles for developing trusting and productive helping relationships.

Principle 1: Be reliable and professional

- Follow through on agreements and commitments made. Nothing damages a relationship of trust more than broken agreements and promises.
- Think before you make a commitment. Anything you agree to or promise must be realistic and possible.
- Be on time for appointments.
- Maintain confidentiality:
 - Any information, including photos, that could implicate an individual or identify locations of drug use should be kept secure.
 - Such information must not be shared with people and agencies that are not directly involved with drug use issues.
 - Clients are unlikely to share information if they suspect that the information will be used against them.
 - Confidentiality is an important ethical component of professional practice.
- Be honest. It is better to say “I cannot give you money to buy drugs” than to say “I don’t have any money.”
- Set firm relationship boundaries.
- Do not personalize.
- Do not respond in a negative or aggressive manner. Clients may be suspicious or aggressive when they do not know you.

Principle 2: Be respectful

- Do not treat clients as if they are children. Society often talks down to people who use drugs and treats them as if they need to be scolded or taught to do the right things.
- Talk to clients in a caring manner.

- Acknowledge and respect clients' vulnerabilities and feelings. Talking to people about their personal histories helps in understanding people's vulnerability, but it may also be painful to the people concerned.
- Avoid visual indications that a client's story is shocking or distasteful.
- Listen respectfully to personal stories.
- Acknowledge and respect clients as the local "experts" on drug use issues. Acknowledging a client's expertise reinforces that the counselor considers the client a valuable individual and enhances the relationship. When clients are treated with respect and as "experts," they are more likely to provide insight into the social and environmental issues that affect their lives.
- Acknowledge when you have learned something new during a conversation.
- Use basic courtesies and compliments. Common basic courtesies and compliments create a sense of humanity and companionship.

Principle 3: Create a relaxed atmosphere

- Make the office and group spaces as inviting as possible. Pictures or posters on the walls contribute to a pleasant "homey" environment.
- Offer refreshments to create a friendly atmosphere.

Principle 4: Be flexible and patient

- Accommodate clients. Building relationships with clients with substance use disorders may mean following their schedules and meeting them at a time and a place that accommodates them.
- Expect that clients will need time to learn new skills; acknowledge any progress or steps taken.
- Be prepared to repeat, repeat, repeat. Repetition is important to learning, particularly when a client is cognitively impaired because of drug use.
- Make sure clients know that you are interested in them as people. Often this means discussing a range of problems that clients are concerned about, such as their health needs, social issues, and criminal involvement, before you can focus on drug use issues.

Principle 5: Share your own experiences appropriately

- Do not focus on yourself and do not assume that your story is similar to another's in all ways.
- Maintain appropriate boundaries. Sharing details is not necessary or desirable.
- Do not tell "drug stories" (e.g., "I remember one time ...").
- Beware of sharing too much personal information.

Principle 6: Listen, listen, listen

- Spend time listening; show understanding of others' feelings.
- Do not be distracted by other activities when talking with clients.
- Maintain eye contact to affirm that you are listening.
- Demonstrate that you are listening without judgment. Clients often have no one with whom to share their feelings. They may be abused in their homes and may have been harshly treated by society, their families, or the police.
- Listen carefully to understand the context and situations in which incidents have occurred.
- Display an understanding of clients' feelings. This skill shows that you are being empathetic and a good counselor.
- Ask about the good things about using drugs. Clients expect you to ask them about all the bad things associated with their drug use; they do not expect you to show interest in knowing about the things they enjoy about drug use. For example, ask:
 - People usually use drugs because they help in some way. How have they helped you?
 - What are some of the good things about...?
 - What do you like about the effects of ...?
 - What would you miss if you weren't ...?
 - What else do you like about...?
- Ask about the "less good" aspects of drug use. For example, ask:
 - Can you tell me about the down side?
 - What are some things you are not so happy about?
 - What are the things you won't miss?
 - How does your drug use fit in with your goal of ...?
 - If you continue as you are, how do you see yourself 3 years from now?
- Use motivational enhancement techniques. These techniques will give you an idea of which stage of change a client is in.

Module 2—The Helping Relationship, Summary

Introduction

- One simple definition of helping relationship is: The relationship between a counselor and a client and the means by which the professional hopes to engage with, support, and facilitate change in a client.
- Understanding the helping relationship includes understanding the client (the person with a problem and/or issue), the counselor (the person acting as a helper/facilitator), and the goal of the helping relationship (to help a client mobilize his or her strengths to solve problems).
- Fundamentally, counseling is a process of empowerment. The key to the helping relationship is to remember that, as a counselor, you are working to:
 - Facilitate your clients' understanding of themselves and their problems;
 - Teach your clients strategies for change and the skills needed to identify and solve problems; and
 - Support your clients in their change processes.
- Empowerment is a term frequently used in the counseling field. Unfortunately, it has many definitions, so it is not always clear what we mean when we use the term. For our purposes, we define empowerment as having:
 - The power, confidence, and skills to make healthful and productive choices (while moving away from self-destructive choices); and
 - A range of options from which to make these choices, including alternatives to self-destructive choices.
- The ultimate goal of the helper is to enable clients to reach their own decisions concerning a course of action that will resolve the problems they face. It is important for clients to learn to solve their own problems and resolve their own issues.
- In summary, the counselor's job is to ensure that clients have the skills, knowledge, and confidence to solve their own problems. But first, the counselor needs to establish a trusting working relationship.

Counselor self-disclosure

- Your relationship with a client may resemble a friendship in some ways. However, as a counselor you must be vigilant to ensure that a healthy and responsible professional relationship develops. Although counseling is a process that requires you as the counselor to be genuinely and authentically engaged with the client, it is critical that you also maintain clear and consistent relationship boundaries.
- We're all familiar with the concept of physical boundaries as they pertain to geography. Countries have boundaries. There are state, regional, and property boundaries. There are boundaries (often fences) around personal property.

- Personal and professional boundaries are just as important. Boundaries set limits on behavior, help define us and our relationships, clarify expectations and give us rules about our roles, and ultimately protect us and others. When a counselor share (or imposes) his or her values and beliefs onto a client, an ethical boundary has been crossed.
- Counselor self-disclosure means sharing things about your own life and experiences with a client.
- Self-disclosure can be very therapeutic for the client and can help advance the treatment process. Disclosing too little can even slow down the process. However, self-disclosure can be potentially damaging to the client and to the helping relationship.
- On the positive side, counselor self-disclosure can:
 - Reduce client feelings of being alone in a certain situation;
 - Promote feelings of empathy in the counselor;
 - Increase the client's perception of the counselor as trustworthy;
 - Increase client self-disclosure;
 - An example of counselor self-disclosure may be: A therapist can share the difficulties he/she has faced in dealing with anger management and how he/she coped with them. If well managed, it can make the person served feel understood and at the same time, modeling can make learning new skills easier. If poorly handled, it can make the person served feel inferior or think the therapist is boasting about his or her capabilities as a counselor.
 - Increase the client's expression of feelings and self-exploration;
 - Elicit new perceptions from the client; and
 - Be used for modeling new roles and behaviors.
- Counselor self-disclosure can also have negative effects. For example:
 - It can be seen as threatening or lead to misunderstandings about the nature of the relationship.
 - It can blur relationship boundaries.
 - Disclosing too much can lead to the client perceiving the addiction counselor as lacking discretion, being untrustworthy or self-preoccupied, or needing therapy himself or herself.
 - The same disclosure that is positive later in the relationship may be negative early in the relationship—timing matters.
 - Premature feedback about a client's attitude or behavior can contribute to a client's feeling inferior or rejected.
 - Too much disclosure does not allow the client to talk.

- One fundamental rule is that counselor self-disclosure must be done for the client's benefit and not to meet the counselor's needs or desires. The counselor also needs to be comfortable sharing information and should not feel that he or she needs to answer every question a client asks.
- In the field of counseling for substance use disorders, a common example of self-disclosure is a counselor's sharing with a client that he is himself in recovery. This information may be very useful for a client and may reinforce the relationship. It is not necessary, however, to share this information, and some counselors are uncomfortable talking about their recovery status with clients.
- Remember, the more time a counselor spends talking about him or herself, the less time is left for the client to talk. Self-disclosure should be used sparingly; otherwise, it can become a barrier to counseling.
- Self-disclosure should always be a thoughtful act. Before self-disclosing, ask yourself these questions:
 - Do I feel comfortable telling this piece of information about myself to my client?
 - Is it safe for me to reveal this information?
 - Will this disclosure benefit my client?
 - Can my client use this information to advance treatment?
 - Will my client view this disclosure as helpful?
- If the answer to any of these questions is no, then you should not disclose the personal information. Remember: There is always a certain amount of risk to both the client and the counselor any time the professional discloses anything of a personal nature.
- The window for self-disclosure will open many times in the counseling relationship; there is no need to rush. For new counselors it is best to err on the side of not disclosing. Counselors should discuss the appropriate use of self-disclosure with supervisors.

Dual relationships

- Related to self-disclosure is the issue of dual relationships. A dual relationship exists when a counselor serves both in the capacity of counselor and in at least one other role (for example, social, financial, professional) with the same client. A dual relationship can occur at the same time as the helping relationship or after the helping relationship has formally ended.
- Although codes of ethics for most professions clearly advise that dual relationships between counselors and clients be avoided, it is not always easy to avoid them entirely. Some dual relationships are clearly harmful and avoidable, such as when a counselor begins a romantic or intimate relationship with a client. You also can (and should) choose not to hire your client to paint your house or choose not to sell your car to a client.

⁵Lawson, G. W., Lawson, A. W., & Rivers, P. C. (2001). *Essentials of chemical dependency counseling* (3rd ed.). Rockville, MD: Aspen Publications.

- Networks of relationships are the nature of community. In rural areas and small villages in particular, chance encounters and casual dual relationships are hard to avoid. For example, your client might work at the only market in the neighborhood. Or you may run into a client at your church, temple, or mosque. Or the person who cuts your hair may appear at your treatment center looking for help. And of course, the counselor in recovery is likely to run into a client at a mutual-help group meeting or a gathering of people in recovery.
- Dual relationships also occur in large cities, where there are smaller communities or districts. Often, treatment counselors provide services to those in their own ethnic, religious, or cultural group.
- The experienced counselor can predict chance encounters and handle them smoothly and warmly. These situations do pose practical challenges, but several creative strategies can be used to prevent or minimize these kinds of dual relationships. For example, when a counselor runs into a client unexpectedly, the counselor can allow the client either to acknowledge the counselor or to ignore the counselor, being respectful of the client's privacy and confidentiality.
- Those who are also members of mutual-help groups can maintain appropriate boundaries between these two roles. For example, the counselor may need to avoid attending meetings that current or former clients attend, if possible. At the very least, it would be inappropriate for a counselor to become a client's sponsor. Counselors may continue to attend the same meetings when necessary but choose not to share personal issues openly in the group. Instead, they might seek support primarily from a sponsor (or peer helper).
- Counselors may have choices about where to receive services themselves (even seemingly trivial services like haircuts, dental cleanings, and banking can be awkward or worse). Counselors are sometimes forced to make intentional decisions about where they become "the client," even if the service is a fairly public one like cutting hair.
- When such relationships cannot be avoided, the counselor can consciously try to remain as neutral as possible and maintain boundaries between the relationships. For example, if a counselor needs to do business with a client, he can avoid talking about the client's personal issues when business is conducted and avoid talking about business in counseling sessions.
- Talk with the client in advance about the likelihood of an encounter or wait for the client to indicate how situations involving dual relationships should be handled.

Transference and counter-transference

- Transference in counseling is a process in which a client transfers onto the counselor attitudes, feelings, and desires from significant personal relationships. It often occurs as an unconscious process based on a client's childhood experiences where feelings such as love, hate, ambivalence, anger, and/or dependency emerge and are directed toward the counselor.⁶

- As the helping relationship deepens, counseling may trigger feelings related to the client's previous connections with other significant people. The client may then begin to experience interactions with the counselor in much the same way the client experienced interactions with a significant person from the past.
- Transference can be either positive or negative, depending on the client's past experiences. For example, sometimes transference can deepen the helping relationship when the client attributes positive traits to the counselor.
- Often, though, transference can distort in a negative way how the client perceives and reacts to the counselor. This can be confusing for the counselor, unless he or she is aware of and alert to the possibility.
- When transference occurs, it often involves a misperception of the counselor (positive or negative). Here are some examples:
 - The client may see the counselor as being perfect in every way (perhaps due to an unconscious reminder of someone the client looked up to as a child). This may result in the client viewing himself or herself as "less than" the counselor.
 - The client may see the counselor as a nurturer and play the "helpless" role. The client may become overly dependent on the counselor, and the counselor may get caught up in feeling sorry for the client and remain in the nurturing role. The client may expect more from the relationship than is possible or not learn how to take personal responsibility.
 - The client may see the counselor as an authority figure and assume the counselor is judging him or her. The client may feel intimidated, be reluctant to be open during counseling, and perhaps even experience some anxiety about the relationship. This could result in the client being quiet in sessions, being passive-aggressive with the counselor (subtle signs of hostility toward the counselor), or constantly trying to please the counselor (for fear of being looked down upon).
- Counselors must be alert to signs of transference. An aware counselor can use transference to gain insight into the client's personality and interactions with family members and peers. For example, if the client attempts to make the counselor look bad in a situation, perhaps this is how the client treats others. Or, if the client sees the counselor as an authority figure and experiences anxiety and intimidation, he or she may be easily intimidated by others.
- It is important that the counselor gain awareness of the client's transference so that he or she does not react to it in a way that is counter-therapeutic for the client.
- Countertransference occurs when the counselor transfers onto a client feelings and attitudes about other people in his or her past or present personal life. For example, a counselor raising a troublesome teenager may react to a teenage client in the same way he or she reacts to his or her own child.

⁶Corey, G., Corey, M., & Callanan, P. (2011). *Issues and ethics in the helping professions*. Pacific Grove, CA: Brooks/Cole

- Here are some examples of countertransference:
 - A counselor with abandonment issues is worried that the client will leave treatment if he/ she confronts the client. He/she sees the premature termination of treatment as personal rejection. Excessive caretaking takes the form of trying to protect the client from any difficulties and taking on the client's problems as the counselor's own to solve.
 - A counselor is intimidated by the client's anger at him/her or others. When the counselor is in the presence of this client, he/she becomes self-conscious and guarded. When the client cancels a session, the counselor finds him/herself relieved.
 - The client has had a very difficult life. No matter how hard he tries, things don't work out, in spite of his best efforts. The counselor goes out of his/her way to be helpful to this client to the extent that he becomes dependent on the counselor.
- Regardless of its origins, countertransference can harm the therapeutic relationship if it is not identified and addressed. Countertransference can lead to a counselor's losing his or her objectivity regarding the client and to interventions that are not in the client's best interest.
- Countertransference is normal and it is something every counselor experiences. The main issue for the counselor is to be able to recognize it and effectively process it so that it does not negatively impact the client.
- To prevent countertransference, it is important that counselors:
 - Do their own emotional work on their past and present issues -be as knowledgeable as possible about their own areas of emotional vulnerabilities and unresolved emotional issues and seek professional help to address these issues;
 - Be aware of the possibility of countertransference; and
 - Discuss their feelings and attitudes toward clients with a supervisor or trusted co-worker to identify countertransference before it interferes with the helping relationship.

Non-verbal communication

- Our facial expressions, eye contact, gestures, posture, and spatial position can "say" just as much as our words (in fact, many think they communicate more). There is a saying that is appropriate here: "A picture is worth a thousand words."
- Our non-verbal communication is largely unconscious. We learn non-verbal communication at a very early age from our families, our peers, and our culture.
- A counselor, however, must learn to attend to his or her client's non-verbal cues and at the same time be aware of his or her own cues.
- Let's take a look at some of the elements of non-verbal communication. First, facial expressions. Facial expressions are an exception to the learned rule; they appear to be universal. Sad looks the same from culture to culture, as does angry.

- Of course, facial expressions are not always so clear-cut, often because our emotions are not always clear-cut. And, of course, there are individual and cultural variations. For some cultures (such as American Indian and some Asian cultures) emotional expression is not encouraged. But for many people, a person's facial expression can be a big clue to what he or she is feeling.
- One non-verbal communication that is very much influenced by culture is eye contact. People from one culture may consider making direct eye contact while talking with someone a sign of interest and respect, whereas those from another culture may see it as intrusive, dominating, or disrespectful.
- Gestures also are largely culture based. Of course, every culture has gestures it considers rude and insulting. Beyond that, though, gestures mean different things in different cultures. Making broad gestures while talking may be seen as expressive and the norm by people in one culture, whereas the same gestures may seem intimidating by those in another culture.
- Spatial position and the use of touch are other elements of non-verbal communication that vary by culture. Spatial position includes the concept of personal space, or how close to another person we can be and still feel comfortable.
- Each of us has an invisible boundary around our body into which other people may not come. If someone crosses this boundary, we feel uncomfortable and will move away to create a more comfortable distance.
- One's personal space will vary depending on the relationship, of course. We will be much more comfortable being very close to family members, romantic partners, or friends and less comfortable being very close to a stranger or casual acquaintance.
- Touching is related to the concept of personal space and is influenced by culture as well as by personal preferences. For some people, a light touch on the hand or shoulder will feel comforting and caring; for others, it may feel like an invasion.
- It is important for a counselor to be very aware of a client's personal space and not violate it. The safest course is not to touch a client (other than a quick handshake), at least until you have a well-established, trusting relationship. Be aware that people who have been physically or sexually abused often have particularly strict personal space requirements. People with certain mental illnesses also may have either very strong or very weak personal space boundaries.
- As a counselor, it's also important that you clearly maintain your own boundaries regarding personal space and touch and that you learn what touching means to each client. It is important that clients feel they are safe in the counseling setting.
- Other non-verbal communication tends to be fairly consistent across cultures. These types of non-verbal behavior include responses to anxiety such as trembling, rubbing or twisting one's hands, and fidgeting. We all have particular non-verbal ways of responding.
- Resource Page 2.1 has some tips for successful non-verbal communication.

MODULE 3

COUNSELING THEORIES AND APPROACHES, AND CORE COUNSELING SKILLS

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Content and Timeline	
Activity	Time
Welcome, review of day 1, and introduction to Module 3	10 minutes
Presentation: Counseling Theories and Approaches	40 minutes
Presentation: Listening—What could be easier?	15 minutes
Presentation: Reflective listening—Simple reflection	15 minutes
Partner exercise: Simple reflection	25 minutes
Presentation: Reflective listening—Amplified reflection	10 minutes
Presentation: Reflective Listening – Double-sided reflection	10 minutes
<i>Break</i>	<i>15 minutes</i>
Small-group exercise: Three types of reflection	50 minutes
Small-group exercise: Reflective listening—Slow-motion role-play	85 minutes
<i>Lunch</i>	<i>60 minutes</i>
Presentation: Open-ended questions	15 minutes
Partner exercise: Open-ended questions	20 minutes
Presentation: Affirming	15 minutes
Group exercise: Affirming	20 minutes
Presentation: Summarizing	15 minutes
<i>Break</i>	<i>15 minutes</i>
Partner exercise: Summarizing	25 minutes
Partner practice session	30 minutes
Presentation: Intentionality in counseling	5 minutes
Day 2 Wrap-up	15 minutes

Module 3 Goals and Objectives

Training goals

- To provide basic information about common counseling theories and approaches
- To provide information about reflective listening and other basic counseling skill techniques for establishing rapport; and
- To provide an opportunity to practice basic counseling skills.

Learning objectives

Participants who complete Module 3 will be able to:

- Explain basic information about common counseling theories and approaches.
- Explain the concept and types of reflective listening and demonstrate beginning skills in reflective listening
- Explain and demonstrate asking open-ended questions
- Explain and demonstrate affirming
- Explain and demonstrate summarizing



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for Addiction Professionals



MODULE 3—COUNSELING THEORIES AND APPROACHES, AND CORE COUNSELING SKILLS



THE COLOMBO PLAN

DAP
Drug Advisory Programme

Basic Counseling Skills

- Reflective listening
- Asking open-ended questions
- Affirming
- Summarizing
- Rolling with resistance

3.2

"Core" Skills

- Those skills that are essential to all types/models of counseling:
 - Assessment
 - Individual
 - Group
 - Family engagement
 - Working with individuals with co-occurring disorders

3.3

Module 3 Learning Objectives

- Explain basic information about common counseling theories and approaches.
- Explain the concept and types of reflective listening and demonstrate beginning skills in reflective listening
- Explain and demonstrate asking open-ended questions
- Explain and demonstrate affirming
- Explain and demonstrate summarizing
- Explain and demonstrate ways of rolling with resistance.

3.4

Psychoanalytic Theory

There
are no
mistakes.

— Sigmund Freud

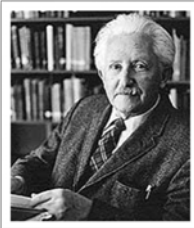


- The Psychoanalytic theory was developed by Sigmund Freud (1856 – 1939) and the therapy based on this theory is referred to as 'psychoanalysis'.
- Though Freud's classical psychoanalysis is not practiced in SUD treatment settings today, many concepts introduced by Freud are widely used.
- Defense mechanisms, transference and counter-transference issues are some of his contributions.
- Freud's theory of psychosexual development has five stages: Oral, Anal, Phallic, Genital & Latent stage of development

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3.5

1. Psychosocial Development Theory



- Erikson's Individual life cycle development – Psychosocial Development
- Erik Erikson (1902-1994) developed the theory of psychosocial development which describes eight stages of development. Like Freud, Erikson also conceptualized the development of personality as taking place in stages. However, Erikson focused on the social influences in the development of the personality.
- Of the eight stages, the first five stages focus on the individual's development of identity and skills while the last three stages are largely related to interpersonal issues.
- Erikson believed that in each stage specific tasks needed to be mastered. Each stage built on the previous stage and the outcome paved the way for the next stage of development.
- Erikson's theory of development holds that psychosexual growth and psychosocial growth take place together, and that at each stage of life people face the task of establishing equilibrium between ourselves and social world.

3.6

2. Adlerian Theory



- Alfred Adler (1870 – 1937) worked closely with Freud and later developed his own approach
- Adler differed from Freud and viewed personality as being influenced by:
 - Interpersonal issues (social connectedness) rather than by intra-psychic conflicts only
 - Conscious, goal - directed, purposeful activity rather than being determined by conflicts at the level of the unconscious. Adler stressed on individual choice and responsibility.
- Adler emphasized the need to:
 - View clients holistically and as part of the social systems he lives in and is recognized as the first therapist to use the systems approach
 - Understand the client's values, beliefs, attitudes and goals and his individual perception of reality even though it is subjective. Rudolf Dreikurs is credited for applying Adler's ideas in various fields.

3.7

4. Existential Therapy

- Existential psychotherapy is an attitude toward human suffering that has no manual. It asks deep questions about the nature of the human being and the nature of anxiety, despair, grief, loneliness, isolation and anomie.
- The goal of existential therapy is to assist clients in their exploration of the existential “givens of life”, how these are sometimes ignored or denied and how addressing them can ultimately lead to a deeper, more reflective and meaningful existence.
- Clients in existential therapy are encouraged to assume responsibility for how they are currently choosing to be in their world.
- During the initial phase of counseling, therapist assist clients in identifying and clarifying their assumptions about the world. During the middle phase, they are assisted in more fully examining the source and authority of their present value system. In final phase, it focuses on helping people take what they are learning about themselves and put it into action.
- This approach can be applied to Brief Therapy to focus clients on significant areas as assuming personal responsibility, making a commitment to deciding and acting, and expanding their awareness of their current situation. 3.8

5. Person-centered Approach

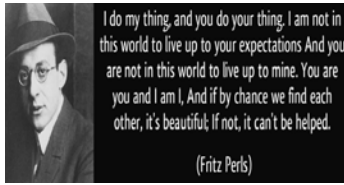


The curious paradox is that when I accept myself just as I am, then I can change.
Carl Rogers

- The Person-centered Approach was largely based on the work of Carl Rogers (1902 –1987).
- Carl Rogers' humanistic approach emphasized that all human beings have potential and will automatically grow in positive ways if provided with the right conditions.
- Person-centered therapy focuses on the person and not the problem. This (phenomenological) approach examines the problem based on the client's perception of experiences rather than the interpretation of the therapist.
- The approach is based on the firm belief that people are capable of healing themselves, move away from maladaptive behavior and towards psychological well being.
- The aim of therapy was to assist clients in their growth process to help them cope better with current and future problems. 3.9

6. Gestalt Therapy

- Frederick S. Perls, usually referred to as Fritz Perls (1893 to 1970) was the chief contributor of the Gestalt therapy.
- As a psychiatrist with training in psychoanalysis, Fritz Perls was influenced by the psychoanalytic concepts.
- Perls took a holistic view of the personality and believed that dealing with the present was more important than the past.
- He also stressed that it was essential for clients to understand 'what they were doing and how' instead of tracing the roots of the problem and understanding 'why'.

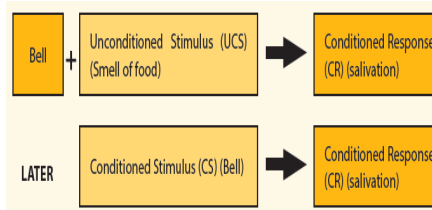


- Gestalt therapy works based on the understanding that people are ultimately in control of their lives and need to accept responsibility for their growth.
- People also have the capacity to change when they become aware of what is happening in and around them.
- Building awareness is the core issue in Gestalt therapy.

3.10

7. Behavior Therapy

- In this approach the focus is on changing observable behavior, identifying current influences on the behavior and developing an intervention to promote change.
- Initially, behavior therapy was developed based on principles related to: Classical conditioning, Operant conditioning and Social learning theory.
- Over time any individual or object associated with the Unconditional Stimulus (UCS) can bring about the same response as if exposed to the UCS. This is called as a Conditioned Response (CR).
- In Pavlov's experiment, the food was presented after ringing a bell. This was repeatedly done and over a period of time the dog started salivating at the sound of the bell. In this situation, the bell is the Conditioned Stimulus (CS) and the dog's salivation was the Conditioned Response (CR).



3.11

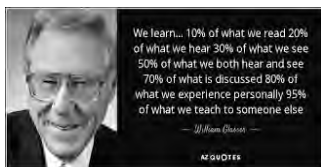
8. Cognitive Behavior Approaches

- Cognitive-Behavior Therapy (CBT) combines cognitive and behavioral principles.
- CBT has been used in variety of settings and groups and has generated more amount of research evidence than any other approach.
- The core idea in CBT is that:
 - Thought disturbances lead to psychological distress
 - By changing thought patterns, one could change feelings and behaviors.
- Specific therapies based on CBT principles are:
 1. Rational Emotive Behavior Therapy (REBT) developed by Albert Ellis who is referred to as the 'grandfather of cognitive-behavior therapy'.
 2. Cognitive therapy was developed by Aaron Beck.
 3. Cognitive-behavior modification was by Donald Meichenbaum.
- All the therapies focus on the present, are directive, problem oriented, and make use of homework assignments.



3.12

9. Reality Therapy



- William Glasser (b.1925) is largely credited for this approach. Glasser worked on the 'Control Theory' developed by William Powers which emphasized that clients accept responsibility for their behavior.
- Later, by working on it for about 10 years, he developed the 'Choice Theory'.
- Reality therapy is based on this 'Choice Theory'.
- 'Choice Theory' states that we are born with five needs that drives our lives – Survival, Love and belonging, Power or achievement, Freedom or independence and Fun. When one or more of these needs are not met, we are in pain and try to find ways to feel better.
- Reality therapist's belief that the underlying problem of most people lies in the fact that they are in unsatisfying relationships.
- The goal of reality therapy is to help people fulfill their needs by providing them with the tools to make the changes they desire.

3.13

10. Feminist Therapy

- Feminist therapy has been a collective effort Jean Baker Miller, Carol Zerke Enns, Olivia M. Espin, Lauara S. Brown.
- The central concept in feminist therapy is the importance of understanding and acknowledging the psychological oppression of women and the constraints imposed by the sociopolitical status to which women have been relegated.
- The goals of feminist therapy include empowerment, valuing and affirming diversity, striving for change rather than adjustment, equality, balancing independence and interdependence, social change, and self-nurturance.
- The therapist's role varies from sharing themselves during the therapy hour, modeling proactive behaviors and being committed to their own consciousness-raising process to having a unique assumptions they hold in feminism.
- Feminist therapists tailor interventions to clients' strength with the goal of empowering clients while evoking their feminist consciousness.

3.14

11. Postmodern Approaches: Solution-focused Brief Therapy



- Steve de Shazer was the first to consider the solution-focused approach. Solution-focused brief therapy was developed in collaboration with many other therapists including Insoo Kim Berg.
- Solution-focused therapies focus on the present and future and not on the past.
- SFBT focuses on where people are and helps find solutions. This is done by focusing on parts of their lives that are going well rather than focusing on the problem parts of their lives.
- Importance is given to help clients define their goals. Goals are stated positively, are focused on doing something about it and structured in the 'here and now'. The solutions are identified by the client and achievable.
- The goal can be focused on changing the way one views the situation, changing the way one contributes to the problem development or by using client's strengths and resources to alter the situation.

3.15

12. Family System Therapy

- Family system therapy is represented by a variety of theories and approaches, all of which focus on the relational aspects of human problems.
- A family systems perspective holds that individuals are best understood through assessing the interactions between and among family members.
- The family systemic therapist may explore the system for family process and rules, using a genogram, and is concerned with transgenerational meanings, rules, cultural and gender perspectives within the system, and even the community and larger systems affecting the family.
- Whereas the family therapist focuses on obtaining accurate diagnosis, causes, purposes, cognitive, emotional and behavioral process.

3.16

"Listen, Listen, Listen"

- In the context of counseling, listening is actually a complex skill and needs to be practiced



3.17

Barriers to Listening

- There are many things that can get in the way of listening



3.18

Barriers to Listening (continued)

- Emotional indifference or reactivity
- Thinking about how to respond while the speaker is still speaking
- Paying attention to something else in the environment
- Dwelling on preconceived attitudes or biases
- Thinking about something in our own lives
- Daydreaming
- Judging the speaker's actions or thoughts

3.19

Reflective Listening

- An *active* form of listening
- Making a reasonable guess about what the client means
- Rephrasing the client's statement to reflect what the counselor thinks he or she heard

3.20

Reflective Listening (continued)

- Reduces the likelihood of resistance
- Encourages clients to talk
- Communicates respect and empathy
- Solidifies the helping relationship
- Reinforces clients' motivation for change

3.21

Reflective Listening (continued)

- Reflective listening requires the counselor to *think* reflectively, understanding that:
 - ▣ People frequently make assumptions about what others mean when they talk
 - ▣ This process is not always conscious
 - ▣ Reflecting back to the client is a way of confirming rather than assuming what the client means



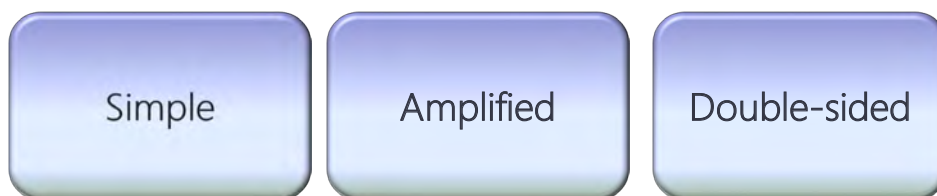
3.22

Reflective Listening (continued)

- True reflective listening requires:
 - ▣ Paying attention to the client's verbal and non-verbal responses and their possible meanings
 - ▣ Understanding the communication style of the client's culture
 - ▣ Forming simple reflections that have meaning to the client
 - ▣ Maintaining flexibility in understanding the client's behavior

3.23

Types of Reflection



3.24

Simple Reflection (or *Paraphrasing*)

- Involves listening for content and observing affect
- Reflects the client's statement back to him or her in a simple, neutral form but without just repeating the client's words verbatim
- Is delivered as a statement rather than a question
- Is helpful when establishing rapport

3.25

Simple Reflection: Examples

- **Client:** I don't plan to quit shooting up anytime soon.
- **Counselor:** You can't see yourself *not* using right now.

- **Client:** And as if that weren't enough, my wife and I aren't getting along at all these days.
- **Counselor:** You're having some problems in your marriage right now, too.

3.26

Simple Reflection: Examples (continued)

- **Client:** I am starting to feel better now that I am in treatment, but I can't help wondering whether my boss will take me back after I get out of treatment.
- **Counselor:** So, you have mixed feelings; you are feeling better physically, but worried about whether or not you will still have a job when you get discharged.

3.27

Simple Reflection: Examples (continued)

- **Client (*angrily*):** I wouldn't be in this situation if my wife hadn't stupidly called my boss.
- **Counselor:** You're pretty angry at your wife right now.

3.28

Simple Reflection: Benefits

- Acknowledges and validates what the client has said
- Lets the client know that the counselor is attentive and understanding
- Helps keep the client focused
- Encourages elaboration

3.29

Partner Exercise: Simple Reflection

- Roles: talker and listener
- Talker will start telling the listener about the process of getting to this training (work arrangements, travel, etc.)
- Listener will practice providing simple reflection
- After 5 minutes, switch roles

3.30

Reflection Exercise: Process

- **Talker:** How did it feel to receive a simple reflection? Did it help you feel heard?
 - ▣ Was there a particular reflection that you really liked?
- **Listener:** How did it feel to reflect? Was it easy? Difficult? Did it help you feel more engaged?
 - ▣ How did your partner seem to react to your reflections? Nodding? Saying more about the topic? Not reacting?

3.31

Amplified Reflection

- Adds to simple reflection by reflecting the client's statement in an expanded, but not sarcastic, form
- May help the client think about what he or she is saying
- Can move the client toward positive change rather than resistance
- Be careful not to make the client feel worse

3.32

Amplified Reflection (continued)

- May open the door for the counselor to explore further



3.33

Amplified Reflection: Examples

- **Client:** I know I've made mistakes, but this stuff they're making me do is ridiculous.
- **Counselor:** You don't agree with any of what they're making you do.
- **Client:** Well, I know I need to do some things to make this right. I'm just really frustrated with all these meetings.

3.34

Amplified Reflection: Examples (continued)

- **Client:** You have to realize that I have been with the same group of friends for over 10 years—I've known them longer than I've known my wife!
- **Counselor:** So, you value your friendships more than your family.
- **Client:** No, no, I didn't mean that; my family is really important to me.

3.35

Double-Sided Reflection

- Acknowledges what the client has said, but also states contrary things he or she has said in the past
- Requires the use of information that the client has offered previously
- May work best—or, at least, be easiest—later in the counseling relationship

3.36

Double-Sided Reflection: Examples

- **Client:** Maybe I should give up using completely, but I'm not going to do that!
- **Counselor:** On the one hand, you can see there are some real problems here, but quitting entirely is not what you want to do. On the other hand, you've said you're worried about the effects of your use on your children. It must be confusing for you.

3.37

Double-Sided Reflection: Examples (continued)

- **Client:** My family means everything to me!
- **Counselor:** I'm a little confused here; on one hand you're saying that your family means everything to you, but on the other hand you are not willing to give up relationships with friends who may be a threat to your recovery.

3.38

Break

15 minutes

3.39

Small-Group Exercise: 3 Types of Reflection

- 10 minutes to create as many examples of your group's type of reflection as possible
- 3 parts to each example:
 - ▣ Client statement
 - ▣ Counselor's reflection
 - ▣ Client's reaction
- Write them down and select 2 group members to present them to the large group

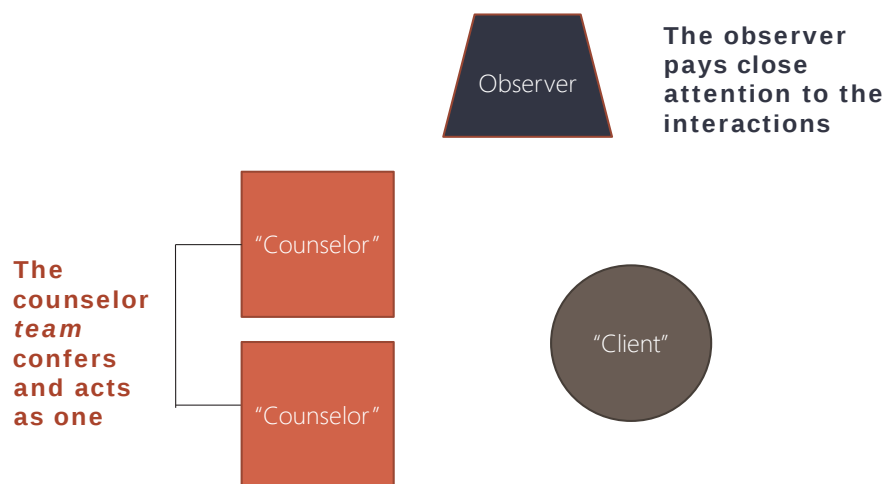
3.40

Small-Group Exercise: Slow Motion Role-Play

- Resource Page 3.1: Exercise Instructions
- Resource Page 3.2: Client Scenarios
- Resource Page 3.3: Help Sheet

3.41

Small-Group Exercise: Slow Motion Role-Play (continued)



3.42

3 Types of Reflective Listening

- **Simple Reflection:** Reflecting a client's statement by paraphrasing
- **Amplified Reflection:** Reflecting a client's statement in an expanded, but not sarcastic, form
- **Double-sided Reflection:** Reflecting a client's statement, but adding something the client has said that is contrary to the first statement

3.43

Processing the Role-Plays

- “Counselors” and “client” share:
 - What the experience was like for each
 - What worked
 - What might have worked better
- The observer shares:
 - Any observations about the process
 - The types of reflective listening heard

3.44

Reflective Listening

- Reflective listening is a core skill you will use in every encounter and with any model of treatment
- Counselor must be constantly attentive
- It's hard work



3.45

Lunch

60 minutes

3.46

Asking Questions: The Down Side

- Counselors may mistake questioning for good listening
- Intensive questioning can:
 - Interfere with the spontaneous flow of communication
 - Divert communication in directions of interest to the counselor rather than the client

3.47

Questioning Guidelines

- Center questions on the client's concerns
- Ask only one question at a time
- Avoid blame- or shame-oriented questions;
- Before asking a question, determine whether it is legitimate and therapeutic and how it should be phrased to provide the most effective result

3.48

Open-Ended Questions

- Cannot be answered “yes” or “no”
- Cannot be answered with one or two words
- Require explanation
- Are thought provoking
- Are not rhetorical
- Sometimes are not even framed as a question

Source: Blowin' in the Wind, Bob Dylan

3.49

Closed vs. Open-Ended Questions

Closed Questions	Open-ended Questions
Do you think you use amphetamines too often?	In what ways are you concerned about your use of amphetamines?
How much marijuana do you smoke a day?	Tell me about your marijuana use during a typical week.
So, you are here because you are concerned about your use of heroin, correct?	Tell me, what is it that brings you here today?

3.50

Open-Ended Questions...

- Help the counselor understand his or her clients' points of view
- Elicit clients' feelings about a situation
- Facilitate dialogue
- Solicit additional information in a neutral way

3.51

Open-Ended Questions (continued)

- Encourage the client to do most of the talking
- Help the counselor avoid making prejudgments
- Keep communication moving forward

3.52

Partner Exercise: Open-Ended Questions

- Find a partner and have a conversation using open-ended questions
- Each person should use reflective listening and open-ended questions
- Process:
 - ▣ What was it like to be the questioner? Was it difficult or easy to come up with open-ended questions?
 - ▣ What was it like to be questioned?

3.53

Affirming

- What does it mean to be affirming?

3.54

Affirming (continued)

- Making a statement about a person that is sincere and positive



3.55

Affirming (continued)

- Affirming promotes a client's feelings of *self-efficacy*

3.56

Self-Efficacy: Definition

- A person's belief in his or her ability to succeed in a particular situation



3.57

Self-Efficacy and Social Persuasion

- People can be persuaded to believe that they have the skills and capabilities to succeed
- Getting verbal encouragement and affirmation from others helps people overcome self-doubt and enhances their self-efficacy

Cherry, K. *What is self-efficacy?* Retrieved March 1, 2012, from http://psychology.about.com/od/theoriesofpersonality/a/self_efficacy.htm

3.58

Affirming: Benefits

- Acknowledges clients' difficulties
- Validates their experiences and feelings
- Prevents discouragement

3.59

Affirming: Examples

- I appreciate how hard it must have been for you to decide to come here; you took a big step
- I'm impressed that you were able to say "no" to your brother this weekend
- That's a really good suggestion

3.60

Group Exercise: Affirming

- Stand up and form a circle
- When you have the ball, affirm someone in the circle or make an affirmation to the whole group
- Give the ball to someone else

3.61

Summarizing: Definition

- Distilling the essence of what a client has expressed—or what has happened in a counseling session—and communicating it back to the client

3.62

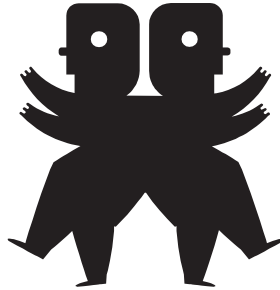
Summarizing

- Summaries help clients by—
 - ▣ Reinforcing what they said
 - ▣ Demonstrating that the counselor has been listening carefully
 - ▣ Helping them consider their responses and experiences
 - ▣ Preparing them to move forward

3.63

Summarizing (continued)

- Summaries can point out discrepancies between substance use behavior and goals



3.64

Summarizing (continued)

- A good way to review previous sessions and to end a current session
- Is useful for group as well as individual sessions
- A link between sessions (group or individual)

3.65

Summarizing Can...

- Affirm the progress a client or group is making
- Remind clients of any commitments they have made
- Reinforce homework assignments

3.66

Summarizing: Example

■ **Counselor:** “We covered a lot of ground today, Richard. We talked about the great success you had in saying “no” to your brother’s offer of cocaine. Although it felt really frustrating at the time, you ended up feeling good about yourself afterwards. Did I get that right? We also talked about some problems you’re having with time management, and you agreed to write down a schedule for the next week and see how that works for you.

3.67

Summarizing

- Encourage clients to correct summaries!
 - **Counselor:** "Did I get it right?"
 - **Richard:** "It wasn't frustrating, exactly, but I felt kind of guilty because my brother felt bad when I walked away."

3.68

Summarizing (continued)

- Can be strategic:
 - The counselor can select what information to include and what to minimize or leave out
 - Reinforce positives and minimize negatives

3.69

Break

15 minutes

3.70

Partner Exercise: Summarizing

- Think through what you want to say and take a few notes
- Take turns summarizing your previous conversation

3.71

Partner Exercise: Skills Practice

- Select a partner
- Decide which skills you each want to practice
- Take turns practicing
- Give each other feedback
- Use a client scenario from Resource Page 3.2, base your practice on a client you know, or be yourselves

3.72

Intentionality in counseling

- Selecting helping behaviors and specific strategies with a clear purpose and direction in mind
- Research links intentionality with positive treatment outcomes



Schmidt, J. J. (1994). Counselor intentionality and effective helping. *ERIC Digest*. Retrieved March 1, 2012, from <http://www.eric.ed.gov/PDFS/ED378461.pdf>

3.73

The Intentional Counselor

- “In sum, the intentional counselor is one who learns many helping strategies, continues to accumulate knowledge of human development and related critical issues, and offers clients a relationship in which all possibilities can be explored, examined, and evaluated.”

Schmidt, J. J. (1994). Counselor intentionality and effective helping. *ERIC Digest*. Retrieved July 22, 2011, from <http://www.eric.ed.gov/PDFS/ED378461.pdf>

3.74

Day 2 Wrap-up

3.75

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1. *Psychoanalytic Theory and approaches*

Background

- The Psychoanalytic theory was developed by Sigmund Freud (1856 – 1939) and the therapy based on this theory is referred to as 'psychoanalysis'.
- Sigmund Freud is recognised for developing the most comprehensive theory of personality and this formed the foundation on which many other theories were developed.
- Though Freud's classical psychoanalysis is not practiced in SUD treatment settings today, many concepts introduced by Freud are widely used.
- Defense mechanisms, transference and countertransference issues are some of his contributions.
- View of personality and symptom development
- Freud believed that the person's personality is shaped by unconscious needs and drives. He believed that the conscious mind is only a small part and that most of our experiences and memories are in the unconscious. Therapy thus focused on recognising the unconscious influences and developing new ways to deal with it.
- Freud's approach is termed as 'deterministic' as personality was believed to be shaped largely by early childhood experiences and not based on the person's freewill.
- Personality development takes place in five stages and is well formed by six years of age. If the child's needs were not adequately met, personality development would be affected. Three stages of development:

Oral stage: First year of life: Nurturing relationship with the caregiver usually the mother would develop the ability to love and trust others. If this stage's need is not met, greed, inability to trust others and difficulty in intimate relationships would follow.

Anal stage: 1 – 3 years of life: Learns independence and expresses feelings of anger and aggression. If not, the helplessness interferes with his sense of autonomy and the person is unable to recognise, express and deal with negative feelings.

- Phallic stage: 3 – 6 years of age: In this stage sexual attitudes develop based on how the parents and caregivers respond. The child learns to be comfortable with his sexual identity.
- Freud also described the stage of latency (6 to 12 years) when sexual interests are replaced with school, sports and other social relationships.

- The rest of the life period was described as the genital stage.
- Freud believed that the personality consists of three psychological structures:
 - The Id, Ego and Superego
 - These do not operate separately but the personality functions based on these three components.

¹Ranganathan, D. S., & Thirumagal, D. V. (2016). ICCE Credentialing Examinations: Study Guide for Addiction Professionals (2nd Edition ed.): Colombo Plan International Centre for Credentialing and Education of Addiction Professionals.

²Corey G, Theory and Practice of Counseling and Psychotherapy, Ninth Edition, Thomson Brooks, CA, 2013.

Component and principle		Role
Id	■ Biological component: present at birth ■ Pleasure principle ■ Functions based on instinct	■ Operates unconsciously or without awareness ■ Illogical, and demanding ■ Driven to satisfy needs and drives ■ Does not think but acts
Ego	■ Psychological component ■ Reality principle ■ Functions based on logic and reality	■ Uses intelligence and plan of action to satisfy needs ■ Functions like an executive to balance instinct and moral code
Superego	■ Social component ■ Perfection principle ■ Operates from the moral code based on values and ideals of parents and society	■ Judicial branch of personality ■ Represents the ideal of what he wants to be ■ Seeks perfection

- There is a constant struggle between the three components giving rise to anxiety.
 - The id seeks to satisfy the basic aggressive and sexual drives.
 - The superego wants to restrict the id and make sure that we behave based on what parents or society wants us to do.
 - The ego tries to negotiate between the two and maintain a balance.
- This gives rise to anxiety as there is a constant fear that :
 - Instinct or id will get out of hand and one would act based on instinct and do something wrong
 - One would not act according to the superego leading to guilt.
- Ego defence mechanisms help the individual cope with the anxiety. Defence mechanisms deny or distort reality and operate in the unconscious. These are normal behaviours that help us adapt as long it is not used to avoid facing reality.
- Some of the common defence mechanisms are :

Defense mechanism		Example
Repression	Thoughts and feelings are suppressed unconsciously	Forgetting things that are painful or unpleasant, e.g. accident or trauma
Denial	Not being able to accept something that is true or real.	Being unable to recognise that one is addicted when the evidence is clear. It generally operates at preconscious and conscious level.
Displacement	Transferring your feelings to someone else not connected with the incident	Being angry with spouse and instead shouting at the child unnecessarily
Projection	Seeing the unwanted aspects of yourself in others	Being jealous and stating that others are jealous, saying "those people out there, but not by me"
Reaction formation:	Dealing with unwanted emotions by expressing the opposite impulse	Being very nice to others when you dislike them
Rationalization	Giving "good" reasons that are not true to explain something uncomfortable	Missing the job promotion and saying that it is better that way as it would have been stressful and boring if he had got it.
Sublimation	Diverting aggressive energy into other socially acceptable behaviour	Diverting aggressive feelings into sports to express feelings and, as an added bonus, is often praised.
Regression	Going back to an earlier stage of development when stressed	Children may start thumb sucking, bed wetting or using baby talk again when stressed or frightened at school.

Defense mechanism		Example
Introjection	Taking in and "swallowing" the values and standards of others	Incorporation of parental values or the attributes and values of the therapist. Some prisoners dealt with overwhelming anxiety by accepting the values of the enemy through identification with the aggressor.
Identification	Identifying with successful causes, organisations, or people in the hope that he/she will be perceived as worthwhile	Wearing expensive clothes to display his worthiness.
Compensation	Masking perceived weakness or developing certain positive traits to make up for that	The person may say "Don't see the ways in which I am inferior, but see me in my accomplishments"

Role of therapist:

- Goal of therapy is to bring the unconscious to the level of the conscious
- This helps strengthen the ego and help develop behaviour based on reality instead of instinct or guilt.
- Childhood experiences are discussed, interpreted and analysed to :
 - Experience the feelings related to the memories
 - Gain understanding of the reason behind the symptoms (why)
 - Identify and understand defence mechanisms and
 - Gain more control over their lives.
- The therapist maintains a 'blank screen approach' making it easy for the client to talk without hesitation about whatever comes to his mind (free association). Dream analysis is another tool used.
- By allowing the client to be on the couch and maintaining an objective, aloof approach the therapist makes it easy for the client to talk about conflicts. Resistances are seen as defences against anxiety.
- The client usually shifts the feelings related to others on to the therapist and this is referred to as transference. These positive and negative feelings expressed towards the therapist are interpreted to hasten the process of getting in touch with the unconscious. The therapist watches for countertransference issues that can affect interpretations.

Strengths and challenges:

- The focus on early developmental tasks, importance of understanding roots of symptom development and handling client resistance are significant contributions of the approach.
- The long duration of therapy and the money involved makes it less appealing.
- Psychoanalysis deals with long-term personality changes and may not be suitable for those who approach the therapist to deal with a crisis.
- This nondirective approach may not be appealing for clients who prefer a more structured approach to treatment.
- Some of the psychoanalytic concepts can be applied while conducting psychodynamic group therapy. Even when the process of psychoanalysis is not used, the group therapist can think psychoanalytically to understand how a person's past is influencing the way they act in groups and their daily lives.
- Group situations often recreate early life situations of clients. Transference towards the therapist and other group members is common. Clients tend to express feelings of anger, avoidance, competition or even attraction which reflect their early relationships. This can help the therapist identify and deal with the unresolved conflicts.
- Recognition of therapist factors influencing therapy through countertransference is also a contribution of the approach. Countertransference issues can help one become aware of own biases, remain sensitive to cultural issues and use the power of the group with care.

Later developments in the Psychoanalytic approach of Sigmund Freud.

- The psychoanalytic approach was further developed by others who built on Freud's concepts. Some are:
 - Carl Jung who emphasised that people are driven to find meaning in life and work to fulfil their capabilities and are not influenced by instincts alone. Jung also believed that people strive towards living up to their potential.
 - Alfred Adler who worked with Freud and Jung later developed his own approach which is discussed in the next section.
 - Later neo-Freudians such as Karen Horney, Erich Fromm and Harry Stack Sullivan contributed to this approach.
 - Psychodynamic approaches (different from psychoanalytic approaches) were later developed which offered therapy in a shorter duration. Basic techniques of psychoanalytic therapy such as free association, interpretation etc., were used. But, the focus was on limited objectives rather than restructuring the personality. Moreover, the therapist took a more active role with expression of support, self- disclosure, etc.

2. Erikson's Individual life cycle development – Psychosocial development

Erik Erikson (1902-1994) developed the theory of psychosocial development which describes eight stages of development. Like Freud, Erikson also conceptualised the development of personality as taking place in stages. However, Erikson focused on the social influences in the development of the personality.

Of the eight stages, the first five stages focus on the individual's development of identity and skills while the last three stages are largely related to interpersonal issues. Erikson believed that in each stage specific tasks needed to be mastered. Each stage built on the previous stage and the outcome paved the way for the next stage of development. Erikson's theory of development holds that psychosexual growth and psychosocial growth take place together, and that at each stage of life people face the task of establishing equilibrium between ourselves and social world.

A brief description of each stage is presented below:

Stage 1: From birth to one year of age

Conflict : Trust vs mistrust

In this stage, the child is completely dependent on the parents, usually the mother as the primary caretaker. If the basic physical and emotional needs are met well, the child feels safe and secure. If the caregiver is inconsistent in meeting the child's basic needs such as food or fails to show adequate love and care, the child is unable to develop trust, is guarded and views the world as inconsistent and unpredictable.

Stage 2: Two to three years of age

Conflict : Autonomy vs shame and doubt

From being totally dependent, the child now attempts to do things on his own and develops self-confidence. By feeding or dressing self, using the toilet etc., the child experiences a sense of control and independence. Patience and encouragement from parents helps while demanding or restricting too much or ridiculing early attempts at self-sufficiency, may result shame and doubt. The sense of 'will' and being able to act independently is a key quality in this stage.

Stage 3: Preschool years (four to five years)

Conflict : Initiative vs guilt

The child's curiosity and initiative to try new things in this stage needs to be managed with balanced restrictions and consistent messages. When too many restrictions are placed and even normal playful actions are prohibited the child feels guilty. Balancing

independence with self-control is a key aspect in this stage. With encouragement and help to make appropriate choices, the child takes the initiative to undertake activities and achieves a sense of competence. If he experiences too much disapproval, is restricted or if this is done inconsistently it can build a sense self doubt and guilt and lead to a lack of initiative.

Stage 4: Six to twelve years-

Conflict : Industry vs inferiority

The focus here is on setting and attaining personal goals related to social and academic demands. The child wants to be responsible, do the right things and do it well. When he is successful, a sense of accomplishment and pride in his ability develops. When he is unable to achieve these tasks, he starts doubting his ability to be successful. The sense of competence the child develops is an important aspect of this stage.

Stage 5: Twelve to eighteen years (adolescence)

Conflict: Identity vs role confusion

Being at the cross roads of development, the adolescent is deciding the kind of person he wants to be. Peers and role models have a great deal of influence. They may experiment with variety of activities leading to conflicts with adults about religious or political orientations. Choices regarding careers need to be made and may be contradictory to what the others want them to do. The emphasis is on achieving a self-identity. Achieving a sense of balance between the standards and expectations of society and what they are and want to be is an important aspect of this stage.

Stage 6: Eighteen to thirty five years (early adulthood)

Conflict: Intimacy vs isolation

Intimacy refers to the ability to be close to others by developing friendships, finding a partner and being able to care for and love others. People who developed a strong sense of personal identity are able to move through this stage with ease. They explore and develop close, committed relationships. On the other hand, people with a poor sense of self are more likely to feel isolated, and suffer from loneliness and depression. They may find it difficult to commit themselves into lasting relationships and move in and out of relationships.

³Ranganathan, D. S., & Thirumagal, D. V. (2016). ICCE Credentialing Examinations: Study Guide for Addiction Professionals (2nd Edition ed.): Colombo Plan International Centre for Credentialing and Education of Addiction Professionals.

Stage 7: Thirty five to sixty five years

Conflict : Generativity vs stagnation

Here the focus is on the career and the family and about helping the next generation. 'Generativity' refers to caring for others and doing things that make the world a better place. Recognising the contribution they have made, taking pride in one's achievements and watching their children grow into adulthood are important aspects of this stage. When the person sees oneself as being unable to contribute and remain uninvolved with their community and with society as a whole, 'stagnation' sets in. Blaming, complaining and being dissatisfied with oneself and others can result.

Stage 8: Sixty five years and above

Conflict : Integrity vs despair

Being able to reflect back on his life with a sense of satisfaction and feel worthwhile marks a successful achievement of this stage of development. They accept the aging process gracefully and see death as part of the life cycle. People, who feel that their life has been wasted or that they have been cheated, feel angry and resentful and bitterness and despair can set in.

3. Adlerian Theory⁴

Background

- Alfred Adler (1870 – 1937) worked closely with Freud and later developed his own approach.
- Adler differed from Freud and viewed personality as being influenced by:
 - Interpersonal issues (social connectedness) rather than by intrapsychic conflicts only
 - Conscious, goal - directed, purposeful activity rather than being determined by conflicts at the level of the unconscious. Adler stressed on individual choice and responsibility.
- Adler emphasised the need to:
 - View clients holistically and as part of the social systems he lives in and is recognised as the first therapist to use the systems approach
 - Understand the client's values, beliefs, attitudes and goals and his individual perception of reality even though it is subjective.
- Rudolf Dreikurs is credited for applying Adler's ideas in various fields.

View of personality and symptom development

- Adler named his approach as 'Individual Psychology'. However, he stressed that people need to be understood as a whole and in relation to all aspects of his life. Adler emphasised the context of family, school, work and culture.
- Adler believed that feelings of inferiority were present in everybody. However this was not viewed in a negative manner. Due to the sense of inferiority, people worked towards developing competence and aim for perfection. It was emphasised that individuals can be understood only in terms of the goals they are working towards.
- Based on the way a person views self, others and the world, he develops a characteristic or a specific way of thinking and acting. This was termed as his 'style of life' or 'road map of life'. This was developed by the time a person is six years old and following events and experiences influence it.
- Interpretation of the events or the way the person viewed these experiences (subjective reality) is considered more important than the actual event.
 - Interpreting these events in a faulty manner can lead to dysfunction.
 - Modifying the faulty assumptions and making changes can help clients create a new style of life.

E.g. The person may believe that nobody cares and decide that he is unlovable. The person may develop depression following this and he avoids contact with others which further intensifies the depression. During therapy he will learn to challenge his logic that he is unlovable.

- Social interest is another distinct concept of Adler. He believed that feelings of inferiority reduced when people were able to relate to others meaningfully and contribute to the welfare of others. The psychological capacity for friendship and belonging, contribution and self-worth and cooperation was fundamental for healthy functioning. Dysfunction in any of these was an indication of psychological disorder (American Psychiatric Association, 2000).

⁴Ranganathan, D. S., & Thirumagal, D. V. (2016). ICCE Credentialing Examinations: Study Guide for Addiction Professionals (2nd Edition ed.): Colombo Plan International Centre for Credentialing and Education of Addiction Professionals.

- Mastery over three universal life tasks was considered important:
 - Building friendship (social task)
 - Establishing intimacy (love – marriage task)
 - Contributing to society (occupational task)
- Later, other therapists (Dreikurs and Mosak) added need for self acceptance and developing our spiritual dimension (including values, life goals etc.,). The aim of therapy was to help clients modify their life style and achieve these tasks.

Role of therapist

Adlerian counseling can be examined as a four phase process.

Phase 1: Establish the relationship. The therapist focuses on the person rather than the problem and builds a positive relationship by listening, responding and expressing hope and faith in their ability to change. The caring relationship is considered important.

Phase 2: Exploring the psychological dynamics: Based on detailed interviewing with the client, an assessment is carried out to understand

- Family constellation: Family atmosphere, birth order and cultural issues
- Early recollection of incidents that happened before the age of 10
- Identifying mistakes in the messages drawn from the past.

Phase 3: Encouraging self understanding and insight: The findings of the assessment are interpreted and carefully presented to help the person understand:

- What motivates the behaviour
- How this contributes to the problem and
- What can be done to correct it

Phase 4: Reorientation and re-education: The insight developed is used to make changes in his life. The therapists may act as the teacher or guide and provide information and encouragement to help make the change. In this phase, encouragement is seen as the most important tool.

Strengths and challenges

- Recognising the importance of social influences and the freedom of choice that the individual has in shaping his destiny are significant strengths of this approach.
- The importance to cultural issues and the flexibility involved made it possible to apply the Adlerian approach to variety of settings and groups (couple counseling, parent education, group counseling etc.)

- The basic ideas have been used by several other approaches and almost all of the approaches presented in the following sections.
- Some of the challenges in applying this approach are:
 - Clients may not recognise the purpose of detailed analysis of one's early life experiences to deal with current problems.
 - In some cultures, the therapist is expected to function as an expert and provides solutions for their problems. In this approach, the therapist focus on teaching alternative ways to cope with the problem can be disappointing.
- Some of Adler's concepts can be used in SUD treatment. For people with SUD, substance use is often a response to cope with feelings of inferiority and clients can be helped to:
 - Review their interpretation of the past
 - Address faulty assumptions
 - Strengthen their social connection with people around them and there by
 - Strengthen recovery.
- The therapist uses encouragement as a therapy tool and providing hope about recovery is emphasized.
- Research support for the effectiveness however is limited.
- By and large, the ideas presented by Adler are used by other approaches but practice of the Adlerian approach has lost prominence. Carlson and Englar-Carlson (2008) commented saying 'Whereas Adlerian ideas are alive in other theoretical approaches, there is a question whether Adlerian theory as a stand-alone approach is viable in the long-term'.

4. **Existential Therapy⁵**

Background

- Existential psychotherapy is an attitude toward human suffering that has no manual. It asks deep questions about the nature of the human being and the nature of anxiety, despair, grief, loneliness, isolation and anomie.
- Key figures in the development of existential theory are Viktor Frankl, Rollo May and Irvin Yalom and contemporary existential psychotherapy are contributed by Viktor Frankl, Rollo May, Irvin Yalom, and James Bugental.
- The goal of existential therapy is to assist clients in their exploration of the existential "givens of life", how these are sometimes ignored or denied and how addressing them can ultimately lead to a deeper, more reflective and meaningful existence.

- Clients in existential therapy are encouraged to assume responsibility for how they are currently choosing to be in their world.

Key Concepts

- The crucial significance of the existential movement is that it reacts against the tendency to identify therapy with a set of techniques. Instead, it based therapeutic practice on an understanding of what it means to be human.
- The existential tradition seeks a balance between recognising the limits and tragic dimensions of human existence on one hand and the possibilities and opportunities of human life on the other hand. It grew out of a desire to help people engage the dilemmas of contemporary life, such as isolation, alienation and meaninglessness.
- The current focus of the existential approach is on the individual's experience of being in the world alone and facing the anxiety of this isolation.

Therapeutic Goals

- Existential therapy is best considered as an invitation to clients to recognise the ways in which they are not living fully authentic lives and to make choices that will lead to their becoming what they are capable of being.
- An aim of the therapist is to assist clients in moving toward authenticity and learning to recognise when they are deceiving themselves.
- The existential orientation holds that there is no escape from freedom as we will always be held responsible. It also aims at helping clients face anxiety and engage in action that is based on the authentic purpose of creating a worthy existence.

Phases of Existential Counseling

- During the initial phase of counseling, therapist assist clients in identifying and clarifying their assumptions about the world. Clients are invited to define and question the ways in which they perceive and make sense of their existence. They examine their values, beliefs, and assumptions to determine their validity.
- During the middle phase, they are assisted in more fully examining the source and authority of their present value system. This process of self-exploration typically leads to new insights and some restructuring of values and attitudes.
- In the final phase, it focuses on helping people take what they are learning about themselves and put it into action. Transformation is not limited to what takes place during the therapy hour.

⁵Corey G, Theory and Practice of Counseling and Psychotherapy, Ninth Edition, Thomson Brooks, CA, 2013.

Therapist's Function and Role

- Existential therapists are primarily concerned with understanding the subjective world of clients to help them come to new understanding and options. They are especially concerned about clients avoiding responsibility; they consistently invite clients to accept personal responsibility.
- Existential practitioners may make use of technique that originate from diverse theoretical orientations, yet no set of techniques is considered essential.
- Existential therapists encourage experimentation not only within the therapy office but also outside of the therapy setting, based on the belief that life outside therapy is what counts.
- Therapists with an existential orientation usually deal with people who have what could be called a restricted existence. These clients have a limited awareness of themselves and are often vague about the nature of their problems. A therapist's function in this case is to assist clients in seeing the ways in which they constrict their awareness and the cost of such constrictions.

Application of Existential Counseling

- This approach can be applied to Brief Therapy to focus clients on significant areas as assuming personal responsibility, making a commitment to deciding and acting, and expanding their awareness of their current situation.
- This approach can be applied to group counseling where the group can be described as people making a commitment to lifelong journey of self-exploration with these goals: (i) enabling members to become honest with themselves, (ii) widening their perspectives on themselves and the world around them, and (iii) clarifying what gives meaning to their present and future life.

Strengths

- This approach is highly relevant in working in a multicultural context, since the existential approach does not dictate a particular way of viewing or relating to reality.
- This therapy is useful in working with culturally diverse clients because of its focus on universality, or the common ground that we all share.
- It enables clients to examine the degree to which their behaviour is being influenced by social and cultural conditioning. Clients can be challenged to look at the price they are paying for the decisions they have made.

Challenges

- For those who hold a systemic perspective, the existentialists can be criticized on the grounds that they are excessively individualistic and that they ignore the social factors that cause human problems. However, with the advent of the “existential-integrative” model of practice, this situation is beginning to change.
- Another concern is that it is highly focused on the philosophical assumption of self-determination, which may not take into account the complex factors that many people who have been oppressed must deal with. In many cultures, it is not possible to talk about the self and self-determination apart from the context of social network and environmental conditions.
- A major task for the counselor who practices from an existential perspective is to provide enough concrete direction for these clients without taking the responsibility away from them.

5. Person-centered Therapy⁶

Background

- The Person-centered Approach was largely based on the work of Carl Rogers (1902 – 1987).
- When Rogers presented this approach, it was distinctly different from the psychoanalytic approaches that focussed on the past and the behavioural approaches that were being practiced. Techniques such as interpretation, teaching, diagnosis and the idea that the ‘Counselor knows best’ was challenged by Rogers.
- Carl Rogers’ humanistic approach emphasised that all human beings have potential and will automatically grow in positive ways if provided with the right conditions.

View of human nature and therapeutic intervention

- Person-centered therapy focuses on the person and not the problem. This (phenomenological) approach examines the problem based on the client’s perception of experiences rather than the interpretation of the therapist.
- The approach is based on the firm belief that people are capable of healing themselves, and of moving away from maladaptive behaviour towards psychological well being.
- The aim of therapy was to assist clients in their growth process to help them cope better with current and future problems.
- Client-centred therapy views the client as being in a state of incongruence and that there is a difference between the way they are and the way they want to be. e.g., the person with SUD may want to be recognised for his skills and contribution but SUD-related damage prevents this.

- By providing a safe environment, the therapist helps them explore the full range of their experience and deal with it. In the counseling environment, the client feels understood, accepted and safe and is able to :
 - View self, others and their situation more accurately
 - Recognise conflicting and confusing feelings
 - Understand parts of themselves which they had previously ignored
 - Understand and accept others.

Applied to crisis situations (e.g., an illness or a disaster) being heard and understood increases calmness, helps them think clearly and make better decisions. This also helps motivate people to do something to resolve the crisis.

Role of therapist

- The personal characteristics of the therapist and the quality of the client therapist relationship were seen as significant factors for effective outcome.
- In this approach the attitude of the therapist was considered as the most effective and only tool necessary for therapy.
- The three qualities that the therapist needed to possess are:
 1. Congruences: (Genuineness): The inner experience and outer expression match. The counselor can openly express their thoughts, feelings, reaction and attitude. Counselors do not present a false front; their genuineness builds trust.
 2. Unconditional positive regard (acceptance and caring). The Counselor does not judge or express opinions about the 'good or bad' of the client's feelings, thoughts or behaviour. There is an attitude of accepting the client as he is.
 3. Clients are free to express themselves without risking the loss of acceptance by the Counselor. This acceptance is based on recognition of the client's right to have certain feelings or behave in a particular way. It does not mean that it is approval of all behaviour.
 4. Accurate empathetic understanding: (ability to understand the world of client). This involves:
 - Understanding the client's experiences
 - Being sensitive to the feelings and
 - Ability to identify the feelings experienced by the client

This encourages the clients to get in touch with their feelings and recognise their situation.

⁴Ranganathan, D. S., & Thirumagal, D. V. (2016). ICCE Credentialing Examinations: Study Guide for Addiction Professionals (2nd Edition ed.): Colombo Plan International Centre for Credentialing and Education of Addiction Professionals.

Strengths and challenges

- Meeting someone who is truly able to listen and understand may present a truly healing experience for many clients.
- The approach can be applied in variety of cultural settings and can be used in many treatment settings.
- Carl Rogers showed great willingness to subject his approach to research. An extensive body of research reflects the effectiveness of this therapy with a range of client and age groups. However, the research methodology has been criticised by some theorists.
- During group counseling, using these techniques creates an atmosphere wherein people can appreciate and trust themselves and others. This nondirective approach points out that interpretation by a therapist in a group can make members self conscious and slow down the process. Instead interpretations and conclusions should come from clients themselves; members of therapy groups are fully capable of expressing and working towards their own goals.
- The approach has been criticised on certain counts:
 - When clients ask for help to deal with a crisis or cope with everyday problems, they expect a structured approach and a directive Counselor. This approach may not meet their needs.
 - Clients may be uncomfortable with direct expression of empathy or disclosure that is an essential part of this approach.
 - The focus on individual autonomy and personal choices may be uncomfortable for people from a collectivistic cultural background. They may focus more on what is good for the community or family and the common good than on individual choices.
 - The emphasis on the qualities of the Counselor is a challenge. Rogers believed and reported research findings that showed that the greater the levels of caring and accepting behaviours, The better chances of success in therapy. Such a strong focus on the personal qualities of a Counselor can be a barrier.
 - Moreover, the fact that the approach supports clients without being challenging may limit the effectiveness of the intervention.

6. Gestalt therapy⁷

Background

- Frederick S. Perls, usually referred to as Fritz Perls (1893 to 1970) was the chief contributor of the Gestalt therapy. However, it was his wife Laura Posner Perls (1905 – 1990) who is credited for developing the approach through her consistent efforts through the New York Institute for Gestalt Therapy.

- As a psychiatrist with training in psychoanalysis, Fritz Perls was influenced by the psychoanalytic concepts. However, his approach differed significantly.
- Perls' work with brain damaged soldiers helped him recognise the need to understand people in their entirety. Perls took a holistic view of the personality and believed that dealing with the present was more important than the past. He also stressed that it was essential for clients to understand 'what they were doing and how instead of tracing the roots of the problem and understanding 'why'.
- 'Gestalt' is a German word for 'whole'. The term referred to 'a form that cannot be separated into parts without losing its essence'. Gestalt therapists deal with all aspects of a person - thoughts, feelings, behaviours, body movements, memories and dreams. One aspect was not treated as being more important than the other. Even gestures and tone of voice are significant forms of expression and it was important to understand it in relation to the rest of the person.

View of human nature and therapeutic intervention

- Gestalt therapy works based on the understanding that people are ultimately in control of their lives and need to accept responsibility for their growth.
- People also have the capacity to change when they become aware of what is happening in and around them
- 'Building awareness' is the core issue in Gestalt therapy.
- Helping clients recognise their contact with what is happening in and around them is important. Therapy focuses on 're-owning' parts of themselves that they have disowned.
- Unacknowledged feelings need to be brought to the level of awareness and resolved. If not, this 'unfinished business' interferes with functioning and lead to physical sensations or problems.
- In therapy, clients are helped to get in touch with the sensations within their body as well as their thoughts, feelings, images, memories etc. Clients are helped to recognise the level of contact with the external environment – seeing, hearing, behaving etc. Increasing awareness helps clients make informed choices and live meaningfully.
- When people accept all parts of themselves without judging or denying, they can lead meaningful lives.
- Gestalt therapy's focus is on:
 - Here and now
 - What and how
 - I – thou of relating

- Focusing on the past or future is seen as a barrier to understanding and dealing with the present. Gestalt therapy focuses on the present. For example if the client talked about his feelings about an incident that happened earlier, he would be encouraged to become aware of his feelings now and at the present when talking about the incident. The client may be encouraged to enact the past incident as if it was taking place now.
- 'What and how' aspects are explored and the 'why' is not the focus. The therapist may ask the client 'What are you experiencing now?, How are you experiencing the feeling? etc.
- The nature of relationship between the client and therapist is important in this process of change.

Role of therapist

- By directing the process of therapy, the therapist creates an environment that helps clients increase awareness, make their own interpretations and decide how they will act on it.
- The therapist functions as a guide and catalyst, presents experiments to increase awareness and shares observations to help the client change.
- Three stages of integration sequence described by Miriam Polster (1987):
 1. Discovery: Realisation about themselves or a new point of view of a situation or of a relationship
 2. Accommodation: Recognising that they have a choice and try new behaviours
 3. Assimilation: Based on the changes that have taken place, the client changes the way he deals with issues in the external world.

The therapist supports the client in this process by paying attention to body language. Noticing clenched fists may prompt the therapist to ask, "If your hands could speak, what would they say?"

- Encourages 'I' statements
- Invites client to present statements instead of stating their thoughts in question form, for example, "I wonder if I am being unnecessarily anxious?"
- Stays sensitive to metaphors and explores them further. For example, if the client says, "I feel crushed" the therapist may ask 'Who is crushing you? What are your feelings now?'

⁷Ranganathan, D. S., & Thirumagal, D. V. (2016). ICCE Credentialing Examinations: Study Guide for Addiction Professionals (2nd Edition ed.): Colombo Plan International Centre for Credentialing and Education of Addiction Professionals.

- Gestalt therapy uses experiments as tools to increase awareness, bring out emotions or encourage action. Some are presented below:
 - The empty chair technique: People often need help to deal with two aspects of their personality. The client is invited to sit on a chair and play the part of the 'top dog' and talk like the authoritarian, demanding and critical parent part of themselves. Next, the client plays the 'underdog' role in which the helpless, weak and passive part comes in to play. The technique helps the client get in touch with feelings and different aspects of themselves.
 - In other experiments, the person may be asked to imagine a situation they may encounter in future, role play by being the parent, doing something that is the opposite of what they usually do, etc.
 - The client may be encouraged to stay with the feeling and experience it deeply in order to be able to experience it rather than avoid it.
 - In dream work, the client plays the part of every person or event in the dream to recognise the issues involved.
- Developing a trusting relationship with the client, recognising their cultural issues and preparing the client are, of course, all important.

Strengths and challenges

- Gestalt is especially useful in helping people get in touch with conflicting feelings within themselves.
- The focus is on growth and enhancement and the belief that people strive for self actualisation and does not view them as being sick or pathological.
- Gestalt therapy can be engaging and lively for clients.
- It is possible to apply these techniques in group settings.
- Research studies have demonstrated the effectiveness of the approach with variety of groups including substance use.
- Emphasising personal responsibility for growth can be particularly useful in an SUD treatment setting. The focus of getting in touch with feelings to help clients think clearly can be of great help to them in recovery. The empty chair technique can help clients resolve issues of ambivalence.
- Gestalt therapy can be used in variety of cultures because it can be tailored based on the individual. However, open expression of feelings and rehearsing to discuss conflicts with parental figures may be inappropriate in some cultures and needs to be handled carefully.

Some issues of concern are:

- Gestalt approach focuses on building awareness and facilitates a client's own process of recovery. The therapist does not play the role of a teacher to take the process further.
- Experiments can invoke strong feelings and when used by a therapist with inadequate training the effects can be painful and disastrous. Expressing empathy towards the client as well as showing him or her respect are both extremely important; without these two qualities, the situation can easily turn into a situation in which there is an abuse of power on the part of the therapist.
- A great level of training and supervision is required to implement this approach.
- Moreover, therapists need to have a high level of personal growth to play their role appropriately. This restricts application of this approach.

7. Behavioural Therapy⁸

Background

- In this approach the focus is on changing observable behaviour, identifying current influences on the behaviour and developing an intervention to promote change.
- Initially, the focus on this group of therapies was only on behaviour and later on cognition or thinking was also incorporated.
- Initially, behaviour therapy was developed based on principles related to:
 1. Classical conditioning
 2. Operant conditioning
 3. Social learning theory
- Each of these three approaches is discussed below.
- These three approaches explained how behaviour was shaped or developed. However, from the 1970's, the importance of cognition (thoughts and beliefs) was recognised and cognitive elements were included into therapy.
- The distinction between behaviour therapy and cognitive therapy is less in today's practice and therapy addresses behaviour as well as cognition. Today, the term 'cognitive-behaviour therapy' has largely replaced 'behaviour therapy' (Corey G, 2009).
- Behaviour therapy is also referred to as behavioural modification. This approach believes that behaviour is learned and therefore can be unlearned or changed by altering the factors that influence behaviour.
- Classical conditioning was illustrated by Ivan Pavlov through experiments with a dog.

**Unconditioned Stimulus (UCS)
(Smell of food)**

**Unconditioned Response
(UCR) (natural) (Salivation)**

In Pavlov's experiment, a dog salivated to the smell and sight of food. The salivation is a natural or unconditioned response to food.

- Over time any individual or object associated with the Unconditional Stimulus (UCS) can bring about the same response as if exposed to the UCS. This is called as a Conditioned Response (CR).
- In Pavlov's experiment, the food was presented after ringing a bell. This was repeatedly done and over a period of time the dog started salivating at the sound of the bell. In

Bell

**Unconditioned Stimulus (UCS)
(Smell of food)**

**Conditioned Response (CR)
(salivation)**

LATER

**Conditioned Stimulus (CS)
(Bell)**

**Conditioned Response (CR)
(salivation)**

this situation, the bell is the Conditioned Stimulus (CS) and the dog's salivation was the Conditioned Response (CR).

- By the same principle if the bell rang (CS) but no food was provided over a period of time the dog stopped salivating to the sound of the bell.
- Classical conditioning showed that based on what was already learned, one could create the same response by pairing the stimulus with another stimulus.
- Operating conditioning showed how behaviour is learned by the consequences that follow.
 - If the behaviour was reinforced (rewards are available), it increases the behaviour.
 - Using a system of rewards and punishments, behaviour can be shaped.
 - B. F. Skinner (1904-1990) is credited for developing behaviour therapy approaches based on operant conditioning.
 - Behaviour therapy utilises:
- Reinforcements to increase target behaviour
- Punishments to decrease target behaviour

⁸Ranganathan, D. S., & Thirumagal, D. V. (2016). ICCE Credentialing Examinations: Study Guide for Addiction Professionals (2nd Edition ed.): Colombo Plan International Centre for Credentialing and Education of Addiction Professionals.

- a. Positive reinforcement – something of positive value is provided (money, praise, food etc.) to increase or strengthen the behaviour.
- b. Negative reinforcement – something of negative value is removed and this encourages the person to display desired behaviour. Here wanting to escape or avoid the negative stimuli influences behaviour. For example: the fine that was imposed earlier is not collected on account of good performance.
- c. Extinction: By withholding (not giving) the reinforcement previously received, the behaviour that was maintained earlier reduces. For example, if the parent gave what the child wanted after a temper tantrum, the behaviour is reinforced by the parent. If the parent does not give the chocolate bar even after the tantrum, this will eliminate the behaviour through the extinction process.
- d. Punishment or aversive control as a consequence of the behaviour results in decrease of the behaviour. Punishment can be positive or negative:
 - o Positive punishment: The aversive or unpleasant stimulus is given after the unwanted behaviour to reduce the frequency of the unwanted behaviour (e.g. fine imposed after driving over the speed limit).
 - o Negative punishment: A reinforcing or positive stimulus is removed to discourage unwanted behaviour (e.g. the child is not permitted to watch television because the household duty was not done).
- Skinner was opposed to use of punishments and recommended using reinforcements to encourage behaviour change. He believed that punishment does not teach lessons and can be used only after use of reinforcements have been tried.
- Social learning approach was developed by Albert Bandura (1925) wherein the role of observing and learning through role modelling was presented as a important factor in shaping behaviour. The approach which was named Social Learning Theory was later renamed Social Cognitive Theory.

8. Cognitive-behaviour approaches⁹

Background

- Cognitive-Behaviour Therapy (CBT) combines cognitive and behavioural principles.
- CBT has been used in variety of settings and groups and has generated more amount of research evidence than any other approach.
- The core idea in CBT is that:
 - Thought disturbances lead to psychological distress
 - By changing thought patterns one can change feelings and behaviours.
- The theoretical basis of these approaches is similar. All emphasise:

- Collaborative relationship with the client
 - Cognitive disturbances are causes of distress and need to be altered to bring about changes in affect and behaviour
 - Time limited and structured approach to therapy.
- In this section, specific therapies based on CBT principles are discussed:
 - i. Rational Emotive Behaviour Therapy (REBT) developed by Albert Ellis who is referred to as the 'grandfather of cognitive-behaviour therapy'.
 - ii. Cognitive therapy was developed by Aaron Beck.
 - iii. Cognitive-behaviour modification was by Donald Meichenbaum.
 - All the therapies focus on the present, are directive, problem oriented, and make use of homework assignments.

A. Rational Emotive Behavior Therapy (REBT)

- REBT is considered to be the parent of many cognitive-behavioural approaches. Albert Ellis, the developer of this approach acknowledges the contribution of others such as Greek philosophers, neo-Freudians and especially Adler who focused on goals, purpose of life and values.
- People have the potential for rational as well as irrational thinking. Helping people recognise and alter their irrational thought patterns is a core issue in REBT.

View of human nature and therapeutic intervention

- Irrational beliefs are learned during childhood. By repeatedly doing things based on these beliefs, it becomes a part of their thought processes. Ellis believed that there are three irrational 'musts' that lead to symptom development:
 - I must do well and win others approval or else I am no good.
 - Others should treat me kindly and in exactly the way I want them to treat me. If they don't, they are no good and must be condemned.
 - I must get what I want, when I want it and I must not get what I don't want. Otherwise it is a terrible situation and I can't stand it.
- These 'should and musts' create emotional disturbance.
- Blame is seen as the core of most emotional responses and must be stopped.

⁹Ranganathan, D. S., & Thirumagal, D. V. (2016). ICCE Credentialing Examinations: Study Guide for Addiction Professionals (2nd Edition ed.): Colombo Plan International Centre for Credentialing and Education of Addiction Professionals.

- Ellis emphasised that we need to accept ourselves as creatures who will make mistakes and we need to be more accepting of ours as well as other's negatives.
- REBT theory and practice is based on the ABC framework.
 - A - Activating event
 - B - Belief (beliefs, emotions and behaviour)
 - C - Emotional and behavioural consequences or reactions that could be healthy or unhealthy.

Ellis emphasized that the event (A) does not lead to the consequence (C). Instead it was our belief (B) that led to negative feelings or behaviour. Though initially B was only seen as being a belief, later on Ellis recognised the emotional and behavioural elements and added it to the concept of B or belief. As B is the central element, altering it in therapy is the focus.

For example:

- There may be an event (A) such as losing a job which is seen as the trigger for the person feeling depressed. Depression (C) is the consequence but A (loss of job) does not automatically lead to C.
- REBT emphasises the belief (B) is part of the picture and it is this belief that influences the way the event (A) is viewed. If the person believes that the loss of job shows that he is a failure or that he is worthless, this leads to depression as a consequence (C).
- On the other hand, if the loss of job is viewed with a different set of beliefs such as 'these things happen and I can find another one', it would be less likely to lead to depression as a consequence.
- In terms of intervention, D (disputing the belief) could lead to E (effective philosophy) which would create a healthy new set of F (feelings).
- It is emphasised that:
 - One should accept that we are largely responsible for our emotional problems.
 - We have the ability to change.
 - Recognising that our irrational beliefs are the cause of symptoms is important.
 - Identifying these beliefs and making efforts to change our beliefs that lead to feelings and dysfunctional actions is essential.

Role of therapist:

- The REBT therapist accepts clients unconditionally and helps them accept themselves and others. Ellis stated that the two main related goals of REBT was to help clients achieve:
 - Unconditional Self Acceptance (USA) and
 - Unconditional Other Acceptance (UOA).
- On the other hand, Ellis believed that too much of warmth and acceptance expressed by the therapist interfered with therapy. He also believed that people have the ability to change.
- REBT therapists are often open and willing to share their own imperfections and establish an equal, nonthreatening relationship with the client.
- The therapist uses variety of techniques that may be focussed on the cognitive, emotional or behaviour aspect. Some are described below :
- Cognitive methods:
 - Disputing irrational beliefs: The therapist actively questions the client repeatedly to reduce the intensity. E.g. The therapist may ask, 'Why must everything go right for you?'. By helping the client raise questions such as 'How can I become a total failure just because I lost a job? and so on may help the client view the situation differently saying, "It is sad that I lost my job but it is not the end of the world"'.
 - Doing cognitive home work: Home work assignments help the client track the 'shoulds and musts' of their internalised messages and apply the ABC model.
 - Changing one's language: Clients are taught to replace 'shoulds and musts' with preferences. 'E.g. It would be preferable if people treated me with respect'
 - Psycho education methods: Providing information, books or CDs that describe REBT approaches are also helpful.
- Emotive techniques:
 - Rational Emotive Imagery: Clients are helped to imagine the worst thing that could happen to them. Later, they are helped to experience the feelings and imagine themselves thinking, feeling and behaving differently. By repeatedly doing this they are able to function in a healthy manner in real life.
 - Role playing, using humour to show the absurdity (foolishness or funny side) of the situation and shame attacking exercises wherein the person risks doing something that they would not normally do (singing loudly on the street etc.)
- Behavioural techniques:
 - Relaxation, modeling, etc.

B. Cognitive therapy

Background

- Aaron T. Beck developed Cognitive Therapy around the same time as Ellis developed REBT. Though both developed their approaches independently, Cognitive Therapy (CT) shares many techniques with REBT.
- The CT's focus is on recognising and changing negative thoughts and maladaptive beliefs.
- The goal is to change automatic thoughts and restructure them. This is done by encouraging clients to gather evidence in support of their belief.

Basic principles of CT

- Automatic negative thoughts interfere with the way people view reality and these cognitive distortions influence behaviour. Some examples are listed below:
 - Arbitrary inferences: making conclusions without evidence. (e.g. student telling oneself that she will not be able to understand concepts in the training, fail in the exam, people at work and home will be upset, etc. even when the programme has just started).
 - Selective abstraction: ignoring other pieces of information and focussing only on one or few incidents that did not go well (e.g. not doing well in one test and not taking into consideration her other strengths such as her good performance in other tests, her experience in the field, etc.).
 - Overgeneralisation: making a decision based on one incident (e.g. not having good marks in one test means that she will not do well in any of the others tests either).
 - Dichotomous thinking : looking at situations in extremes (e.g. if she did not get a high score, it means it is a failure - passing does not count)
- Clients are helped to identify the distorted, dysfunctional thoughts and test these by examining the evidence for these inferences.
- These thoughts reflect the rules that people live by and when these rules are inappropriate it affects their beliefs and interfere with the way they think. These beliefs need to be examined and altered. For example, when people see themselves as inadequate, they interpret situations in a negative way and by projecting these into the future; they tell themselves that things are going to be difficult. They do not expect things to change and this adds to their negative mood state.
- Clients are often asked questions related to these beliefs. (e.g. Where is the evidence for....?). By repeatedly asking these questions, and carrying out home work assignments based on these assumptions, clients understand how these thoughts influence their actions.

- The client learns ways to modify these negative thought patterns and engage in more realistic ways of thinking.

Role of therapist:

- The therapist develops a case conceptualisation to understand how clients view their world. This is done by helping clients to describe their thoughts, feelings, and behaviour in relation to their environment and their view of the world.
- This case conceptualisation provides a structure and focus to the therapy.
- CT believes in engaging the client in all stages of therapy from identifying thoughts, summarising their understanding and designing homework assignments. The level of involvement of the client contributes to the long-term impact of therapy.
- The therapist establishes a warm, empathetic and collaborative relationship with the client. Socratic dialogue (questions that help the client think) is largely used. E.g., What would happen if you try? How do you know that it is useless to even try?
- The therapist functions as a catalyst and a guide who stays actively involved in the process of identifying and changing thoughts and beliefs.
- Home work may be provided with graded tasks, doing the easier one first and gradually attempting more difficult ones.
- CT has extensive research based evidence of effectiveness especially in relation to depression. The short-term focus and cost effectiveness are strengths of this approach.

C. Cognitive-Behavior Modification (CBM) by Donald Meichenbaum

- CBM focuses on self-talk (statements) that affect the person's behaviour.
- While REBT and CT focus on maladaptive thoughts, CBM focuses on clients becoming aware of their self-talk (instructions they give to themselves).
- Cognitive restructuring (changing the pattern of thinking) is important.
- CBM can be understood as a process that takes place over three phases:
 - Phase 1: Self-observation: clients are helped to become aware of negative self statements and images they carry in their minds. Becoming more sensitive to their feelings and behaviour, they understand how their self-talk influences them.
 - Phase 2: Starting a new internal dialogue with the help of the therapist. By changing the talk, they are able to change their thought patterns.
 - Phase 3: Learning new skills. They learn how to behave differently in real life situations and because of this others also react to them differently.

The stories people tell about themselves and important events in their lives are used to help clients understand how they view reality and how it can be viewed differently. On completion of therapy the same technique can be used to evaluate outcome. Is the client able to describe himself differently, does he take credit for the changes made etc., may be some of the aspects that are considered.

- Coping skills programme developed using this approach has been used with many problems including SUD and stress disorders. Here, role playing and imagery is used to help clients recognise their level of anxiety, the link with their thoughts and changing these by altering their self statements.
- Stress inoculation training was developed using the CBM approach.
 - The clients are helped to understand the nature of stress and the role of thoughts in creating and maintaining stress.
 - The therapist may provide information, use Socratic questioning and help clients understand the stress in terms of the environment.
 - By monitoring their internal statements and the dysfunctional behaviour that follow the statements that they make to themselves, clients become aware of their own role in creating stress.
 - The therapist helps them understand their fears about stressful situations, learn ways to handle their stress by doing something different and learning how to relax. The clients may also learn time management, ways to develop their social skills etc.

Strengths and challenges of the cognitive approaches:

- The empirical evidence that the approach works is a significant strength.
- The structured approach and involvement of the client demystifies therapy and helps the client understand the process of change.
- The shorter duration and focused approach makes it appealing to clients.
- The involvement of clients and making them responsible for the direction of therapy is a positive aspect of this approach.
- As cognitive-behaviour therapy approaches are based on understanding the client's beliefs, it can be easily applied in different cultures.
- REBT's focus on independence can be difficult to use with clients from cultures that value interdependence.
- Cognitive therapy has been criticised for being too technique oriented and focusing only on eliminating the symptoms without understanding the underlying causes.
- Moreover, in these approaches emotions or feelings are not dealt with in detail and the focus is on cognition and behaviour.

9. Reality therapy¹⁰

Background

- William Glasser (b.1925) is largely credited for this approach. Glasser worked on the 'Control Theory' developed by William Powers which emphasised that clients accept responsibility for their behaviour. Later, by working on it for about 10 years, he developed the 'Choice Theory'.
- Reality therapy is based on this 'Choice Theory'.
- Robert Wubbolding extended the practice of reality therapy and made the 'Choice Theory' more practical and usable.
- 'Choice Theory' explains 'why and how' people function in a particular way and reality therapy describes the intervention by which people can be helped to take control of their lives.

View of human nature and therapeutic intervention

- 'Choice Theory' states that we are born with five needs that drives our lives.
 - Survival
 - Love and belonging
 - Power or achievement
 - Freedom or independence
 - Fun.
- When one or more of these needs are not met, we are in pain and try to find ways to feel better.
- All of us have a mental picture of what we would like to have and the ways by which we want to satisfy these needs. We choose to behave in a way that will give us control over our lives and meet these needs. The client may choose a behaviour that is dysfunctional.
- Reality therapist's belief that the underlying problem of most people lies in the fact that they are in unsatisfying relationships. People choose behaviours to deal with the frustration that arises out of poor relationships.
- Glasser believed that anxiety, depression or any other mental disorder are only behaviours that people choose to deal with problems in relationships.
- The goal of reality therapy is to help people fulfil their needs by providing with them tools to make the changes they desire. The focus is on what can be done rather than on what cannot be done.

- Glasser believed that for people to change they need to be:
 - Convinced that the present behaviour is not getting them what they want and
 - Choose other behaviours that will get them closer to what they want.
- Wubbolding used the acronym WDEP to describe the key tasks involved:
 - W – Wants: Clients are helped to discuss their wants and hopes
 - D – Direction and doing: The key question may be ‘what are you doing’
 - E – Evaluation: Asking clients to examine if what they are doing is getting them closer to what they want
 - P – Planning and action: Identifying ways to fulfil their wants and needs.

Role of therapist:

- Reality therapists teach clients to evaluate their present situation, examine effectiveness of choices and emphasise that they are totally in control. The core idea that they convey to the client is that ‘The only person you can control is yourself’.
- The focus in therapy is on the present as needs can be satisfied only in the present. If the client talks about the past, the therapist would listen to it only for a short period of time and focus on what can be done now. Reality therapists often tell clients that the more time one spends in looking back, the more one avoids looking forward.
- Reality therapists do not spend time on discussing the symptoms or even the feelings associated with it. These are seen as ways to avoid focussing on the current, unhappy relationships.
- The therapist functions like a teacher and mentor. Reality therapists are gentle but firm, and focus on issues at hand. The questions raised by the therapist may appear challenging but help clients to evaluate the choices they have made. For example: ‘Is what you are doing getting you closer to the person?’.
- Therapist functions with optimism and deals with clients ‘as if’ they have choices and manages to convey that there is hope.

¹⁰Ranganathan, D. S., & Thirumagal, D. V. (2016). ICCE Credentialing Examinations: Study Guide for Addiction Professionals (2nd Edition ed.): Colombo Plan International Centre for Credentialing and Education of Addiction Professionals.

Strengths and challenges:

- The WDEP system can be easily adapted to group counseling.
- In reality therapy, focus is on helping clients examine their lives, evaluate for themselves and choose ways that can help them achieve their needs. This focus on the client's choices helps reduce resistance in both individual and group settings.
- The focus on doing something about it rather than the focus on insight alone are positive aspects of the approach.
- In SUD treatment settings emphasising personal choice and control works well. Underlying the fact that the only person they can change is themselves is a very important and useful message for clients as well as their families.
- The positive orientation of the therapist about what can be done and that people can change is strength of this approach.
- Being able to provide clients with tools to change during the relatively short-term therapy is another strength of this approach.

Some issues of concern are:

- Even though the approach seems simplistic, applying it with clients can be challenging.
 - The lack of focus on building insight and influence of the past are seen as drawbacks.
 - Reality therapy also does not value the positive effect of expressing feelings and the therapeutic value of catharsis is underplayed.
 - Glasser's view that all mental disorders are chosen behaviours is of concern. Especially with depression, conveying the message that they are choosing to be depressed can add to their guilt.
- There are aspects in life over which one has no control. Some of the limitations may be cultural and issues such as gender imbalance and power issues can restrict choices. Moreover issues like racism, etc., are also challenges that cannot be over looked.

10. Feminist Therapy¹¹

Introduction

- Feminist therapy has been a collective effort Jean Baker Miller, Carol Zerbe Enns, Olivia M. Espin, Lauara S. Brown. It puts intersections of gender, social location, and power at the core of the therapeutic process. It is built on the premise that it is essential to consider the social, cultural and political context that contributes to a person's problems in order to understand that person.

- The central concept in feminist therapy is the importance of understanding and acknowledging the psychological oppression of women and the constraints imposed by the sociopolitical status to which women have been relegated. Its perspectives offer a unique approach to understanding the roles that both women and men have been socialized to accept and to bringing this understanding into the therapeutic process.

Key Concepts

- The constructs of feminist theory has been described as being gender fair, flexible-multicultural, interactionist, and life-span-oriented.
- Feminist therapists emphasize that societal gender-role expectations profoundly influence a person's identity from the moment of birth and become deeply ingrained in adult personality.

Principles

1. The personal is political – this principle is based on the assumption that the personal or individual problems that individuals bring to counseling originate in a political and social context
2. Commitment to social change – Feminists view their therapy practice as existing not only to help individual clients in their struggles but also to advance a transformation in society.
3. Women's and girl's voices and ways of knowing are valued and their experiences are honored – Women are encouraged to value their emotions and their intuition and to use their personal experience as a touchstone for determining what is "reality".
4. The counseling relationship is egalitarian - Feminist therapists recognise that there is a power imbalance in the therapeutic relationship, so they strive for an egalitarian relationship, keep in mind that clients are the experts on their own lives.
5. A focus on strengths and a reformulated definitions of psychological distress – Feminist therapists talk about problems in the context of living and coping skills rather than pathology.
6. All types of oppressions are recognised – Feminist therapists acknowledge that social and political inequities have a negative effect on all people.

Therapeutic Goals

- The goals of feminist therapy include empowerment, valuing and affirming diversity, striving for change rather than adjustment, equality, balancing independence and interdependence, social change, and self-nurturance.

- At the individual level, feminist therapists work to help females and males recognise, claim and embrace their personal power.
- Empowering the client is at the heart of feminist therapy, which is the overarching long-term therapeutic goal.

Therapist's Function and Role

- The therapist's role varies from sharing themselves during the therapy hour, modeling proactive behaviours and being committed to their own consciousness-raising process to having a unique assumptions they hold in feminism.
- Feminist therapists have integrated feminism into their approach to therapy and into their lives. Their actions and beliefs and their personal and professional lives are congruent. They are committed to monitoring their own biases and distortions, especially the social and cultural dimensions of women's experiences.
- They value being emotionally present for their clients.
- Although feminist therapists may use techniques and strategies from other theoretical orientations, they are unique in the feminist assumptions they hold.

Strengths

- The most in common with the multicultural and social justice perspectives. This approach emphasizes the need to promote social, political, and environmental changes within the counseling context like multicultural and social justice counseling approaches.
- It also emphasizes direct action for social change as a part of the role of therapists.
- Feminist therapists believe psychotherapy is inextricably bound to culture, and, increasingly, they are being joined by thoughtful leaders in the field of counseling practice.
- Feminist therapists are committed to taking a critical look at cultural beliefs and practices that discriminate against, subordinate, and restrict the potential of groups of individuals, which can be either a strength or a shortcoming.

¹¹Corey G, Theory and Practice of Counseling and Psychotherapy, Ninth Edition, Thomson Brooks, CA, 2013.

Shortcomings

- Feminist therapists advocate for change in the social structure, especially in the areas of inequality, power in relationships, the right to self-determination, freedom to pursue a career outside or inside the home, and the right to an education. This agenda could pose some problems when working with women who do not share their beliefs.
- Being aware of the cultural context is especially important when feminist therapist work with women from cultures that endorse culturally prescribed roles that keep women in a subservient place or that are grounded in patriarchy.
- The therapist is challenged to work together with the client to find a path that enables her to consider her own individual goals without ignoring or devaluing her collectivistic cultural values.

11. Postmodern Approaches - Solution-Focused Brief Therapy (SFBT)¹²

Background

- Steve de Shazer was the first to consider the solution-focused approach. Solution-focused brief therapy was developed in collaboration with many other therapists including Insoo Kim Berg.
- Apart from SFBT there are many other solution-focused therapies.
- The common ingredients are discussed here.

Key concepts

- Solution-focused therapies focus on the present and future and not on the past. This approach believes that tracing the cause of problems is not necessary because solutions are not related to causes of problems. Moreover, multiple solutions may be available for a problem and what works for one person may not work for the other.
- Diagnosis or history taking is not emphasised.
- SFBT focuses on where people are and helps find solutions. This is done by focusing on parts of their lives that are going well rather than focusing on the problem parts of their lives.
- Four steps of SFBT:
 - Finding out what the client wants.
 - Look for what the client is already doing and which works well.

- If what the client is doing is not working, encourage them to try something different.
- Keep therapy brief; expecting each session to be the last.
- Importance is given to help clients define their goals. Goals are stated positively, are focused on doing something about it and structured in the 'here and now'. The solutions are identified by the client and achievable.
- The goal can be focused on changing the way one views the situation, changing the way one contributes to the problem development or by using client's strengths and resources to alter the situation.
- Some of the techniques used by solution therapists are:
 - Pre-therapy change: Just making an appointment is seen as a positive shift. The therapist may ask, 'What have you done since you made the appointment that has made a difference to your problem?'. This helps the client focus on what they have already done well and brings into focus their own resources to deal with the problem.
 - First session talk: The SFBT therapist on the very first session asks the client to observe things that they enjoy or would like to continue. This is discussed in the second session. This increases the sense of hope and helps the client look at the positives and invites them to build on it.
 - Exception questions: The therapist asks for situations from the client's life which were different – the problem did not exist, the problem was not so intense or it was avoided. This opens the possibility of the identifying solutions. This is often referred to as 'change talk'.

Miracle question: This is SFBT's main technique. The therapist asks 'If a miracle happened and the problem had been solved overnight, how would you know that it was solved and what would be different?' This helps the client shift the ways the problem is viewed, thinks about future possibilities and starts thinking about life in which the problem is not present.

- Scaling questions: Clients are asked to assess the level of their problems on the scale of 0 to 10 and asked to look at where they stand as of now. This helps clients assess where they are and what they can do to make the change they desire.
- Feedback to clients: Every session ends with the feedback of about 5 to 10 minutes. The summary has three parts:

The summary has three parts:

- Complements about what the client is already doing to solve issues.

¹²Ranganathan, D. S., & Thirumagal, D. V. (2016). ICCE Credentialing Examinations: Study Guide for Addiction Professionals (2nd Edition ed.): Colombo Plan International Centre for Credentialing and Education of Addiction Professionals.

- Bridge that links the complement to the tasks or homework that will be given.
- Suggestion about what the client can do. The client may be asked to do something or observe some aspects of their life.
 - Terminating: Therapists frequently asked scaling question to monitor progress.

The therapeutic relationship is terminated when client is able to find a solution. Clients are helped to identify things they would like to continue and additional help is made available whenever needed.

Role of therapist:

- The therapist plays a major role in helping people shift from the problem focused view to a solution-focused one and see the future with new possibilities.
- SFBT believes that people have a capacity to change and that small changes make way for larger changes.
- The client is the expert of what will work for him. The therapist does not play the role of an expert. Walter and Peller (2000) even discouraged the use of the word 'therapy' and suggested that they see the therapist as offering 'personal consultation'.
- The therapist makes a lot of effort to build the collaborative relationship based on respect, trust, open discussion and hope. This is seen as a critical component for therapy.

Strengths and challenges:

- SFBT emphasises the positive, the resources and strengths rather than the negatives.
- The techniques of SFBT can be used in individual as well as group settings
- SFBT is a practical, cost effective approach.
- By focusing on strengths rather than pathology the client is helped to draw on their resources and initiate changes.
- SFBT techniques can be valuable to help clients in recovery from SUD.

12. Family System Therapy¹³

Backgrounds

Family systems is represented by a variety of theories and approaches, all of which focus on the relational aspects of human problems. Some of the individuals most associated with this approach are Alfred Adler, Murray Bowen, Virginia Satir, Carl Whitaker, Salvador Minuchin, Jay Haley and Cloe` Maanes.

Within the family systems, people discover who they are; they develop and change; and they give, receive and support what they need for survival. People create, maintain, and live by often unspoken rules and routines, hoping that will keep the family functional. In this sense, a family systems perspective holds that individuals are best understood through assessing the interactions between and among family members.

The identified clients' problems might be a symptom of how the system functions, not just a system of the individual's maladjustment, history, and psychosocial development. This perspective is grounded on the assumptions that a client's problematic behaviour may

1. serve a function or purpose for the family,
2. be unintentionally maintained by family processes
3. be a function of the family's inability to operate productively especially during developmental transitions
4. be a symptom of dysfunctional patterns handed down across generations.

Differences between Systemic and Individual Approaches

There are significant differences between individual therapeutic approaches and systemic approaches.

- The individual therapist may focus on accurate diagnosis, using the DSM-IV-TR, begin therapy, and focus on the causes, purposes, and cognitive, emotional, and behavioural processes involved. The therapist may be concerned with individual's experiences and perspectives. Intervene in ways designed to help the client cope with the situation.

- The systemic therapist may explore the system for family process and rules, perhaps using a genogram. May invite parents and other siblings with the client. The family relationships within which the continuation of one's situation will be focused. The therapist may be concerned with transgenerational meanings, rules, cultural and gender perspectives within the system, and even the community and larger systems affecting the family. Intervene in ways designed to help change the client's context.

TABLE 14.1 A Comparison of Six Systemic Viewpoints in Family Therapy

	ADLERIAN FAMILY THERAPY	MULTI-GENERATIONAL FAMILY THERAPY	HUMAN VALIDATION PROCESS MODEL	EXPERIENTIAL/ SYMBOLIC FAMILY THERAPY	STRUCTURAL FAMILY THERAPY	STRATEGIC FAMILY THERAPY
<i>Key figures</i>	Afred Adler, Rudolf Dreikurs, Oscar Christensen, & Manford Sonstegard	Murray Bowen	Virginia Satir	Carl Whitaker	Salvador Minuchin	Jay Haley & Cloé Madanes
<i>Time focus</i>	Present with some reference to the past	Present and past: family of origin; three generations	Here and now	Present	Present and past	Present and Future
<i>Therapy goals</i>	Enable parents as leaders; unlock mistaken goals and inter- actional patterns in family; promotion of effective parenting	Differentiate the self; change the individual within the context of the system; decrease anxiety	Promote growth, self-esteem, and connection; help family reach congruent communication and interaction	Promote spontaneity, creativity, autonomy, and ability to play	Restructure family organization; change dysfunctional transactional patterns	Eliminate presenting problem; change dysfunctional patterns; interrupt sequence

<i>Role and function of the therapist</i>	Educator; motivational investigator; collaborator	Guide, objective researcher, teacher; monitor of own reactivity	Active facilitator; resource detective; model for congruence	Family coach; challenger; model for change through play	“Friendly uncle”; stage manager; promoter of change in family structure	Active director of change; problem solver
<i>Process of change</i>	Formation of relationship based on mutual respect; investigation of birth order and mistaken goals, reeducation	Questions and cognitive processes lead to differentiation and understanding of family of origin	Family is helped to move from status quo through chaos to new possibilities and new integrations	Awareness and seeds of change are planted in therapy confrontations	Therapist joins the family in a leadership role; changes structure; sets boundaries	Change occurs through action-oriented directives and paradoxical interventions
<i>Techniques and innovations</i>	Family constellation; typical day; goal disclosure; natural/logical consequences	Genograms; dealing with family-of-origin issues; detriangulating relationships	Empathy; touch, communication; sculpting; role playing; family-life chronology	Co-therapy; self-disclosure; confrontation; use of self as change agent	Joining & accommodating; unbalancing; tracking; boundary making; enactments	Reframing; directives and paradox; amplifying; pretending; enactments

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A multilayered Process of Family Therapy

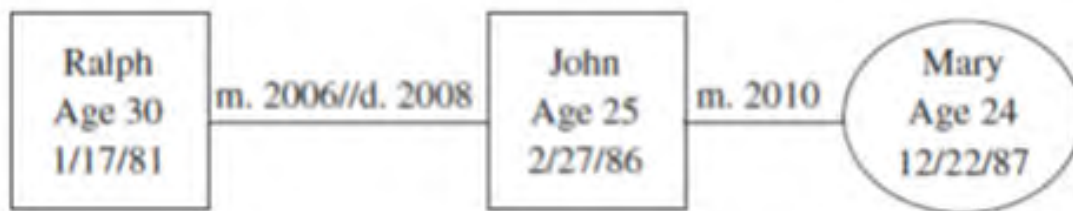
1. Forming Relationship

Therapists begin to form a relationship with clients from the moment of first contact. From the moment of first face-to-face contact, good therapeutic relationships start with efforts at making contact with each person present.

2. Conducting an Assessment

Genograms allow the family structure and stories to be presented in a clearer and more orderly manner. In some cases, formal tests and rating scales also can be useful.

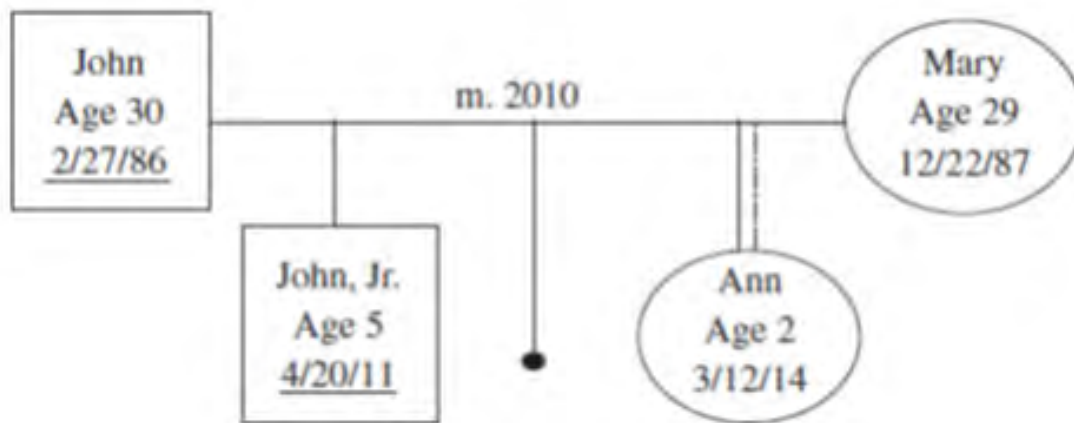
Most family practitioners start with a map of the family that comes to therapy. The parents are listed with their name, age and date of birth in either a rectangle (for men) or a circle (for women). If there are multiple relationships involved in the parental subsystem, they are generally indicated in chronological order with men listed on the left and women on the right.



In the above genogram, Mary married Ralph when she was 20 and Ralph was 26; their marriage lasted about 2 years. and then they were divorced. In 2010, Mary and John were married.

When Mary and John have children, their genogram may look like this.

¹³Corey G, Theory and Practice of Counseling and Psychotherapy, Ninth Edition, Thomson Brooks, CA, 2013.



3. Hypothesizing and Sharing Meaning

To hypothesize is to form a set of ideas about people, systems, and situations that focus meaning in a useful way. In family therapy, hypothesizing flows from the ideas and understanding generated in the assessment process. When a therapist has an idea (based on a hypothesis) and wants to share it, permission for the disclosure is often sought.

- I have an idea I would like to share with you. Would you be willing to hear it?
- Could it be that..

The value of this way of presenting hypotheses is that it invites families and family members to consider and to engage without giving up their right to discard anything that does not fit.

4. Facilitating Change

Facilitating change is what happens when family therapy is viewed as a joint or collaborative process. Two of the most common forms for facilitation of change are enactments and assignment of tasks. Both of these processes work best when the family co-constructs them with the therapist- or at least accepts the rationale for their use. Within the change process, the number of possible outcomes is only limited by the resources available internally and externally to the family.

Strengths

- Since many ethnic and cultural groups place great value on the extended family, if therapists are working with an individual from a cultural background that gives special value to including grandparents, aunts, and uncles in the treatment, it is easy to see that family approaches have a distinct advantage over individual therapy.

Challenges

- The major concern for non-Western cultures would be with regard to the balance that this model advocates for the individual versus the collective.
- The process of differentiation occurs in most cultures, but it takes on a different shape due to cultural norms.

Resource Page 3.2: Slow-Motion Reflective Listening Role-Play Instructions

Introduction

In this small-group exercise, you will take turns playing three roles:

- Client;
- Counselor; and
- Observer.

The “slow-motion” of the exercise is that the “counselor” role is played by two people who will act as a team to respond to the client. New skills are not easy to learn. Slowing your responses and taking the time to learn from one another will reduce some of the stress of role-playing and will help you learn in a thoughtful manner.

Role-play each scenario for 5 minutes, then take 5 minutes to process each role-play. **Switch roles for each scenario.**

Instructions for Each Role-Play

Decide who will play each role. The person who will be the “client” should:

- Turn to Resource Page 3.2 and select a role. Another option is to create a role based on a familiar client;
- Take a minute to plan your approach to the role; and
- Play your role as realistically as possible, based on your experiences.

The “counselor” team should:

- Review the selected “client” role;
- Decide which of you will be the “voice” of the “counselor”;
- Confer before responding to the “client” (slow-motion); and
- Use Resource Page 3.3 Slow-Motion Reflective Listening Role-Play Help Sheet, as needed.

The “observer” should:

- Observe the apparent effects of the reflective listening of the “counselor” team; and
- Try to identify which type of reflective listening the team is using.

Instructions for Processing Each Role-Play

The “counselor” team shares:

- What its experience was like;
- What it thought worked well; and
- What it thought did not work well or what it would do differently next time.

The “client” shares:

- What the experience was like;
- What worked well (what interventions seemed to make him or her feel “heard”); and
- What might have worked better.

The “observer” shares:

- Any observations about the process; and
- The types of reflective listening used.

Resource Page 3.3: Slow-Motion Reflective Listening Role-Play Client Scenarios

Role 1: Tristan

Tristan is 27 years old and has never married. He returned from a 6-month stay in a therapeutic community program 2 months ago. He stayed abstinent while he was there. Tristan has moved back in with his mother (his father is deceased), three siblings, and his grandmother. His mother watches his every move and asks others in his neighborhood to watch him, too. His grandmother won't speak to him because he has shamed the family. He feels like using heroin again and has been meeting old using friends. His attitude is, "Why not? Everything is messed up anyway." Tristan has spoken to the counselor before about how hurt he feels that his grandmother won't speak to him. He was close to her as a child, and her silence hurts.

Role 2: Richard

Richard is 45 years old. He has smoked marijuana two or three times a week since he was in his teens and has "dabbled" in other substance use. He started injecting heroin 3 years ago during a period of unemployment, and his use quickly became out of control. His wife nearly left him, but eventually he received treatment at a residential treatment center and returned to his wife, three children, and his mother-in-law 3 months ago. His wife had a very difficult time while he was away and is angry with him. She is pressuring him to start working and taking care of his family, but he is having trouble finding a job. Everyone in the area knows about him and won't give him a chance. Richard is frustrated and discouraged. He has started spending time away from home to avoid his wife. He has told the counselor that he worries that the effects of his substance use and his time away have affected his children and is afraid of losing his family entirely.

Role 3: Ha

Ha, a 25-year-old female, has been a sex worker since she was 16. Her mother was also a sex worker and died of AIDS a year ago. Ha has used substances for years and started injecting heroin 2 years ago. She is homeless, but stays with friends when she can. Her mother's death has scared her, but she hasn't been tested for HIV. She is ambivalent about being tested. She knows she should be tested, but she is scared of finding out the test results. Ha occasionally goes to a drop-in center. She has told a counselor that she feels "tired and old" and wants to get out of sex work. She doesn't trust the drop-in center staff or volunteers and feels hopeless. Still, she continues to visit the drop-in center.

Role 4: Bakhmura

Bakhmura is an 18-year-old female who started using stimulants with her boyfriend. She says it was fun at first, but her use is getting out of control. She started injecting methamphetamine 2 months ago. Her parents have found out and have threatened to send her to a treatment center. Bakhmura is well educated about HIV and is trying to be careful. She talked to a counselor at a drop-in center once about her use. She is scared that her parents will send her to a center, but she doesn't want to break up with her boyfriend or stop using drugs. She wishes she hadn't started injecting and could still just take pills or snort cocaine "for parties."

Resource Page 3.4: Slow-Motion Reflective Listening Role-Play Help Sheet

Type of Reflective Listening	Description and Example
Simple reflection	- Reflects the client's statement in a neutral form. - Can use the client's exact words or can be rephrased. - Acknowledges and validates what the client has said. Client: I don't plan to quit using any time soon. Counselor: You don't see abstinence in your near future. Client: That's right!
Amplified reflection	- Reflects the client's statement in an exaggerated (but not sarcastic) form. - Can move the client toward positive change rather than resistance. Client: I don't know why my wife is worried about this. I don't drink any more than my friends. Counselor: So there's absolutely no reason for your wife to worry. Client: Well, I can maybe see how she would worry a little.
Double-sided reflection	- Acknowledges what clients have said, but also states contrary things they have said in the past. - Requires the use of information that clients have offered previously, although perhaps not in the same session. Client: Maybe I should give up using completely, but I'm not going to do that! Counselor: On the one hand, you can see that there are some real problems here, but quitting altogether clearly is not what you want to do. On the other hand, you've said you're worried about the effects of your use on your children. It must be confusing for you.

Module 3—Counseling Theories and Approaches, And Core Counseling Skills

- This module focuses on some of the most critical counseling skills:
 - Reflective listening;
 - Asking open-ended questions;
 - Affirming;
 - Summarizing; and
 - Rolling with resistance.
- We are calling these “core” skills because:
 - They are essential across all areas of counseling: you will use them for assessment, individual counseling, group counseling, family engagement, and working with clients with co-occurring disorders;
 - They are relevant across all stages of change; and
 - Although some of these skills are usually associated with motivational enhancement approaches, they are useful no matter what specific theory or practice you use.

Counseling Theories and Approaches

1. PSYCHOANALYTIC THEORY

- The Psychoanalytic theory was developed by Sigmund Freud (1856 – 1939) and the therapy based on this theory is referred to as ‘psychoanalysis’.
- Though Freud’s classical psychoanalysis is not practiced in SUD treatment settings today, many concepts introduced by Freud are widely used.
- Defense mechanisms, transference and counter-transference issues are some of his contributions.
- He described that personality development takes place in five stages and is well formed by six years of age. If the child’s needs were not adequately met, personality development would be affected. Three stages of development:
- Oral Stage: First year of life: Nurturing relationship with the caregiver usually the mother would develop the ability to love and trust others. If this stage’s need is not met, greed, inability to trust others and difficulty in intimate relationships would follow.
 - During this stage, the infant’s primary source of interaction occurs through the mouth, so the rooting and sucking reflex is especially important. The mouth is vital for eating, and the infant derives pleasure from oral stimulation through gratifying activities such as tasting and sucking.

- Because the infant is entirely dependent upon caretakers (who are responsible for feeding the child), the child also develops a sense of trust and comfort through this oral stimulation.
 - The primary conflict at this stage is the weaning process--the child must become less dependent upon caretakers. If fixation occurs at this stage, Freud believed the individual would have issues with dependency or aggression. Oral fixation can result in problems with drinking, eating, smoking, or nail- biting.
- Anal stage: 1 – 3 years of life: Learns independence and expresses feelings of anger and aggression. If not, the helplessness interferes with his sense of autonomy and the person is unable to recognize, express and deal with negative feelings. During the anal stage, the primary focus is on controlling bladder and bowel movements. The major conflict at this stage is toilet training—the child has to learn to control their bodily needs. Developing this control leads to a sense of accomplishment and independence. According to Freud, success at this stage is dependent upon the way in which parents approach toilet training. Parents who utilize praise and rewards for using the toilet at the appropriate time encourage positive outcomes and help children feel capable and productive. Inappropriate parental responses can result in negative outcomes. If parents take an approach that is too lenient, Freud suggested that one’s personality could develop in which the individual has a messy, wasteful, or destructive personality.
 - Phallic stage: 3 – 6 years of age: In this stage sexual attitudes develop based on how the parents and caregivers respond. The child learns to be comfortable with his sexual identity. Freud suggested that during the phallic stage, the primary focus of the libido is on the genitals. At this age, children also begin to discover the differences between males and females.
 - Freud also described the stage of latency (6 to 12 years) when sexual interests are replaced with school, sports and other social relationships. Children develop social skills, values and relationships with peers and adults outside of the family.
 - The rest of the life period was described as the genital stage. The onset of puberty causes the libido to become active once again. During the final stage of psychosexual development, the individual develops a strong sexual interest in the opposite sex. This stage begins during puberty but last throughout the rest of a person’s life.
 - Psychoanalytic counseling theories hold those psychological problems result from the present-day influence of unconscious psychological drives or motivations stemming from past relationships and experiences. Dysfunctional thought and behavior patterns from the past have become unconscious “working models” that guide clients toward continued dysfunctional thought and behavior in their present lives. Psychoanalytic counselors strive to help their clients become aware of these unconscious working models so that their negative influence can be understood and addressed. Some currently preferred therapies grounded in psychoanalytic theory include psychoanalysis, attachment therapy object relations therapy and Adlerian therapy.

2. Psychosocial Development Theory

- Erikson (1902-1994) developed the theory of psychosocial development which describes eight stages of development. Like Freud, Erikson also conceptualized the development of personality as taking place in stages. However, Erikson focused on the social influences in the development of the personality.
- Of the eight stages, the first five stages focus on the individual's development of identity and skills while the last three stages are largely related to interpersonal issues.
- Erikson believed that in each stage specific tasks needed to be mastered. Each stage built on the previous stage and the outcome paved the way for the next stage of development.
- Erikson's theory of development holds that psychosexual growth and psychosocial growth take place together, and that at each stage of life people face the task of establishing equilibrium between ourselves and social world.

3. Adlerian Theory

- Alfred Adler (1870 – 1937) worked closely with Freud and later developed his own approach
- Adler differed from Freud and viewed personality as being influenced by:
 - Interpersonal issues (social connectedness) rather than by intra-psychic conflicts only
 - Conscious, goal - directed, purposeful activity rather than being determined by conflicts at the level of the unconscious. Adler stressed on individual choice and responsibility.
- Adler emphasized the need to:
 - View clients holistically and as part of the social systems he lives in and is recognized as the first therapist to use the systems approach
 - Understand the client's values, beliefs, attitudes and goals and his individual perception of reality even though it is subjective. Rudolf Dreikurs is credited for applying Adler's ideas in various fields.

4. Existential Therapy

- Existential psychotherapy is an attitude toward human suffering that has no manual. It asks deep questions about the nature of the human being and the nature of anxiety, despair, grief, loneliness, isolation and anomie.
- The goal of existential therapy is to assist clients in their exploration of the existential "givens of life", how these are sometimes ignored or denied and how addressing them can ultimately lead to a deeper, more reflective and meaningful existence.
- Clients in existential therapy are encouraged to assume responsibility for how they are currently choosing to be in their world

- During the initial phase of counseling, therapist assist clients in identifying and clarifying their assumptions about the world. Clients are invited to define and questions the ways in which they perceive and make sense of their existence. They examine their values, beliefs, and assumptions to determine their validity.
- During the middle phase, they are assisted in more fully examining the source and authority of their present value system. This process of self-exploration typically leads to new insights and some restructuring of values and attitudes.
- In final phase, it focuses on helping people take what they are learning about themselves and put it into action. Transformation is not limited to what takes place during the therapy hour.
- This approach can be applied to Brief Therapy to focus clients on significant areas as assuming personal responsibility, making a commitment to deciding and acting, and expanding their awareness of their current situation.

5. Person-centered Approach

- The Person-centered Approach was largely based on the work of Carl Rogers (1902–1987).
- Carl Rogers' humanistic approach emphasized that all human beings have potential and will automatically grow in positive ways if provided with the right conditions.
- Person-centered therapy focuses on the person and not the problem. This (phenomenological) approach examines the problem based on the client's perception of experiences rather than the interpretation of the therapist.
- The approach is based on the firm belief that people are capable of healing themselves, move away from maladaptive behavior and towards psychological well being.
- The aim of therapy was to assist clients in their growth process to help them cope better with current and future problems.

6. Gestalt Therapy

- Frederick S. Perls, usually referred to as Fritz Perls (1893 to 1970) was the chief contributor of the Gestalt therapy.
- As a psychiatrist with training in psychoanalysis, Fritz Perls was influenced by the psychoanalytic concepts.
- Perls took a holistic view of the personality and believed that dealing with the present was more important than the past.
- He also stressed that it was essential for clients to understand 'what they were doing and how' instead of tracing the roots of the problem and understanding 'why'.
- Gestalt therapy works based on the understanding that people are ultimately in control of their lives and need to accept responsibility for their growth.

- People also have the capacity to change when they become aware of what is happening in and around them.
- Building awareness is the core issue in Gestalt therapy.

7. Behavior Therapy

- In this approach the focus is on changing observable behavior, identifying current influences on the behavior and developing an intervention to promote change.
- Initially, behavior therapy was developed based on principles related to: Classical conditioning, Operant conditioning and social learning theory.
- Over time any individual or object associated with the Unconditional Stimulus (UCS) can bring about the same response as if exposed to the UCS. This is called as a Conditioned Response (CR).
- In Pavlov's experiment, the food was presented after ringing a bell. This was repeatedly done and over a period of time the dog started salivating at the sound of the bell. In this situation, the bell is the Conditioned Stimulus (CS), and the dog's salivation was the Conditioned Response (CR).

8. Cognitive Behavior Approaches

- Cognitive-Behavior Therapy (CBT) combines cognitive and behavioral principles.
- CBT has been used in variety of settings and groups and has generated more amount of research evidence than any other approach.
- The core idea in CBT is that:
 - Thought disturbances lead to psychological distress
 - By changing thought patterns, one could change feelings and behaviors.
- Specific therapies based on CBT principles are:
 1. *Rational Emotive Behavior Therapy (REBT) developed by Albert Ellis who is referred to as the 'grandfather of cognitive-behavior therapy'.*
 2. *Cognitive therapy was developed by Aaron Beck.*
 3. *Cognitive-behavior modification was by Donald Meichenbaum.*
- All the therapies focus on the present, are directive, problem oriented, and make use of homework assignments.

9. Reality Therapy

- William Glasser (b.1925) is largely credited for this approach. Glasser worked on the 'Control Theory' developed by William Powers which emphasized that clients accept responsibility for their behavior.
- Later, by working on it for about 10 years, he developed the 'Choice Theory'.

- Reality therapy is based on this 'Choice Theory'.
- 'Choice Theory' states that we are born with five needs that drives our lives – Survival, Love and belonging, Power or achievement, Freedom or independence and Fun. When one or more of these needs are not met, we are in pain and try to find ways to feel better.
- Reality therapist's belief that the underlying problem of most people lies in the fact that they are in unsatisfying relationships.
- The goal of reality therapy is to help people fulfill their needs by providing them with the tools to make the changes they desire.

10. Feminist Therapy

- Feminist therapy has been a collective effort Jean Baker Miller, Carol Zerbe Enns, Olivia M. Espin, Lauara S. Brown.
- The central concept in feminist therapy is the importance of understanding and acknowledging the psychological oppression of women and the constraints imposed by the sociopolitical status to which women have been relegated.
- The goals of feminist therapy include empowerment, valuing and affirming diversity, striving for change rather than adjustment, equality, balancing independence and interdependence, social change, and self-nurturance.
- The therapist's role varies from sharing themselves during the therapy hour, modeling proactive behaviors and being committed to their own consciousness-raising process to having a unique assumption they hold in feminism.
- Feminist therapists tailor interventions to clients' strength with the goal of empowering clients while evoking their feminist consciousness.

11. Postmodern Approaches: Solution- focused Brief Therapy

- Steve de Shazer was the first to consider the solution-focused approach. Solution-focused brief therapy was developed in collaboration with many other therapists including Insoo Kim Berg.
- Solution-focused therapies focus on the present and future and not on the past.
- SFBT focuses on where people are and helps find solutions. This is done by focusing on parts of their lives that are going well rather than focusing on the problem parts of their lives.
- Importance is given to help clients define their goals. Goals are stated positively, are focused on doing something about it and structured in the 'here and now'. The solutions are identified by the client and achievable
- The goal can be focused on changing the way one views the situation, changing the way one contributes to the problem development or by using client's strengths and resources to alter the situation.

12. Family System Therapy

- Family system therapy is represented by a variety of theories and approaches, all of which focus on the relational aspects of human problems.
- A family systems perspective holds that individuals are best understood through assessing the interactions between and among family members.
- The family systemic therapist may explore the system for family process and rules, using a genogram, and is concerned with transgenerational meanings, rules, cultural and gender perspectives within the system, and even the community and larger systems affecting the family.
- Whereas the family therapist focuses on obtaining accurate diagnosis, causes, purposes, cognitive, emotional and behavioral process
- Family systems therapy holds to the idea that an individual's system affiliations and interactions have more power in the person's life than a single therapist could ever hope to have.

Core Counseling Skills

- Some of the most critical counseling skills include:
 - Reflective listening;
 - Asking open-ended questions;
 - Affirming;
 - Summarizing; and
 - Rolling with resistance.
- We are calling these "core" skills because:
 - They are essential across all areas of counseling: you will use them for assessment, individual counseling, group counseling, family engagement, and working with clients with co-occurring disorders;
 - They are relevant across all stages of change; and
 - Although some of these skills are usually associated with motivational enhancement approaches, they are useful no matter what specific theory or practice you use.
- Remember that one of the principles of working with clients with SUD was "listen, listen, listen!". We all think we know what it means to listen, we listen to people every day. However, in the context of counseling skills (or even our relationships!), listening is actually a complex skill and needs to be practiced. Even highly experienced counselors don't always get it right.

- There are many things that can get in the way of listening. For example, instead of listening to a sender's entire message, many receivers start thinking about their own upcoming replies or are too quick to apply interpretations to both verbal and nonverbal behaviors. These types of thoughts create barriers in the communication process and can lead to a misunderstanding of the message.
- Some possible barriers to listening include:
 - Emotional indifference or reactivity;
 - Thinking about how to respond while the speaker is still speaking;
 - Paying attention to something else in the environment;
 - Dwelling on preconceived attitudes or biases;
 - Thinking about something in our own lives;
 - Daydreaming; or
 - Judging the speaker's actions or thoughts.
- Unfortunately, counselors are not immune to these barriers! Active listening takes intense openness, concentration, presence, and patience.

Reflective Listening

- We're going to be talking about reflective listening, an active form of listening. Reflective listening involves:
 - Making a reasonable guess about what the client means; and
 - Rephrasing the client's statement to reflect what the counselor thinks he or she heard, giving the client a chance to clarify when necessary.
- Reflective listening is critical to the counselor–client relationship. It:
 - Reduces the likelihood of resistance;
 - Encourages clients to talk;
 - Communicates respect and empathy;
 - Solidifies the helping relationship; and
 - Reinforces clients' motivation for change.
- Reflective listening requires the counselor to think reflectively.
- A crucial aspect of thinking reflectively is understanding that:
 - People frequently make assumptions about what others mean when they talk;
 - This process is not always conscious; and

- Reflecting back to the client is a way of confirming what the client means rather than assuming it.
- True reflective listening requires:
 - Paying attention to the client's verbal and nonverbal responses and their possible meanings;
 - Understanding the communication style of the client's culture;
 - Forming simple reflections that have meaning to the client; and
 - Maintaining flexibility in understanding the client's behavior.
- There are three different types of reflective listening: simple reflection, amplified reflection, and double-sided reflection.

Simple reflection

- Simple reflection, or paraphrasing, is the most basic type of reflection. Simple reflection:
 - Involves listening for content and observing affect;
 - Reflects the client's statement back to him or her in a simple, neutral form without just repeating the client's words verbatim;
 - Is delivered as a statement rather than a question; and
 - Is helpful when establishing rapport.
- Examples of simple reflection would be statements like these:

Client: I don't plan to quit shooting up anytime soon.

Counselor: You can't see yourself not using right now.

Client: And as if that weren't enough, my wife and I aren't getting along at all these days.

Counselor: You're having some problems in your marriage right now, too.

Client: I am starting to feel better now that I am in treatment, but I can't help wondering whether my boss will take me back after I get out of treatment.

Counselor: So, you have mixed feelings; you are feeling better physically, but you're worried about whether or not you will still have a job when you get discharged.

Client (angrily): I wouldn't be in this situation if my wife hadn't stupidly called my boss.

Counselor: You're pretty angry at your wife right now.

- Simple reflection acknowledges and validates what the client has said and lets the client

know that the counselor is attentive and understands what the client is attempting to communicate. It also helps keep the client focused and encourages elaboration.

- Simple reflection is a particularly good tool for early engagement, when the counselor and the client are getting to know each other and are building trust.

Amplified reflection

- Amplified reflection adds to simple reflection by reflecting the client's statement in an expanded, but not sarcastic, form. It may help the client think about what he or she is saying and can move the client toward positive change rather than resistance. It is also important that an amplified reflection is done in a way that avoids making the client feel worse.
- For example, a client may say: "I don't know why my wife is so worried about this. I don't smoke bhang any more than any of my friends." An amplified, slightly exaggerated reflection might be: "So there's absolutely no reason for your wife to be worried."
- This reflection could cause the client to consider whether there is "absolutely no reason" for her to worry, and respond: "Well, I didn't say absolutely no reason."
- Such a response opens the door for the counselor to explore further. For example: "So, there may be some reason for her to be worried? What legitimate reason to worry do you think she might have?"
- Here's another example. A client might say: "I know I've made mistakes, but all of this stuff they're making me do is ridiculous."
- The counselor could respond: "You don't agree with any of what they're making you do."
- This might prompt the client to consider further and respond, "Well, I know I need to do some things to make this right. I'm just really frustrated with all these meetings."
- And one more example:

Client: You have to realize that I have been with the same group of friends for over 10 years—I've known them longer than I've known my wife!

Counselor: So, you value your friendships more than your family.

Client: No, no, I didn't mean that; my family is really important to me.

Double-sided reflection

- The last type of reflective listening is double-sided. Double-sided reflection acknowledges what the client has said, but also states contrary things he or she has said in the past.

- This type of reflection requires the use of information that the client has offered previously, although perhaps not in the same meeting. It may work best—or, at least, be easiest—later in the counseling relationship when the counselor has more history to draw from.
- Here are two examples of double-sided reflection:

Client: Maybe I should give up using completely, but I'm not going to do that!

Counselor: On the one hand, you can see there are some real problems here, but quitting entirely is not what you want to do. On the other hand, you've said you're worried about the effects of your use on your children. It must be confusing for you.

Client: My family means everything to me!

Counselor: I'm a little confused here; on one hand you're saying that your family means everything to you, but on the other hand you are not willing to give up relationships with friends who may be a threat to your recovery.
- Double-sided reflection is basically a “yes, but what about...” approach.

Open-ended Questions

- First, it's important to know that there is a down side to asking questions. Counselors often mistake questioning for good listening. Although a counselor may ask questions to learn more about the client, the underlying message sometimes seems to be that the counselor might find the right answer to all the client's problems if enough questions are asked.
- In fact, intensive questioning can interfere with the spontaneous flow of communication and divert it in directions of interest to the counselor rather than of the client.
- Of course, counselors do need to elicit information from clients that clients may not be eager to share.
- Asking questions can be an effective way of learning about a client and the client's concerns, but certain guidelines should be followed:
 - Center questions on the client's concerns;
 - Ask only one question at a time;
 - Avoid blame- or shame-oriented questions; and
 - Before asking a question, determine whether it is legitimate and therapeutic and how it should be phrased to provide the most effective result.
- The most effective way to phrase questions is usually to make sure they are open-ended.
- *Open-ended* questions are those that:

- Cannot be answered “yes” or “no”?
 - Cannot be answered with one or two words?
 - Require explanation;
 - Are thought provoking;
 - Are not rhetorical (meaning questions that are asked more to make a point than in expectation of an answer; like “How many roads must a man walk down/Before you call him a man?”¹); and
 - Sometimes are not even framed as a question. For example, instead of asking “When did you last use cocaine?” a counselor might say, “Tell me about the last time you used cocaine” to elicit more than a date.
- Of course, open-ended questions are not always the best way to go. Asking a client: “Tell me about where you live” is not the most efficient way to get the client’s address!
- Open-ended questions:
- Help the counselor understand his or her clients’ points of view?
 - Elicit clients’ feelings about a given topic or situation?
 - Facilitate dialogue because they cannot be answered with a single word or phrase and do not require a particular response?
 - Solicit additional information in a neutral way;
 - Encourage the client to do most of the talking?
 - Help the counselor avoid making prejudgments? and
 - Keep communication moving forward.

Affirming

- Affirming is making a statement about a person that is sincere and positive. Affirming is like complimenting, but it says something about a person that is deeper than, “Your hair looks great!”
- One of the most important effects of affirming is that of promoting a client’s feelings of self-efficacy.
- The term self-efficacy was coined by social psychologist Albert Bandura. He defined it as basically a person’s belief in his or her ability to succeed in a particular situation.
- Although a person’s beliefs about his or her abilities begin to form in early childhood, they continue to evolve throughout the life span and can be influenced. For instance, many people find someone they admire (such as a mentor) to emulate or to be motivated by, someone they would like to be like.
- Bandura believed that one critical way in which self-efficacy can be enhanced is

through what he called “social persuasion”: that people can be persuaded to believe that they have the skills and capabilities to succeed. Getting verbal encouragement and affirmation from others helps people overcome self-doubt and enhances their self-efficacy, increasing their confidence and their ability to take action and change behavior.

- Affirming also can strengthen the helping relationship by demonstrating to clients that the counselor acknowledges their difficulties and validates their experiences and feelings. In addition, emphasizing clients’ experiences that demonstrate strength, success, or power prevents discouragement.
- Here are a few examples of affirming statements:
 - I appreciate how hard it must have been for you to decide to come here. You took a big step.
 - I’m impressed that you were able to say “no” to your brother this weekend.
 - That’s a really good suggestion.

Summarizing

- *Summarizing* is distilling the essence of what a client has expressed—or what has happened in a counseling session—and communicating it back to the client. It is different from simple reflection in that it is not a reflection of a statement, but a summary of a conversation or counseling session.
- Summaries help clients by:
 - Reinforcing what they said;
 - Demonstrating that the counselor has been listening carefully;
 - Helping them consider their responses and experiences; and
 - Preparing them to move forward.
- A summary that links the client’s positive and negative feelings about substance use can also help the client see his or her ambivalence and any discrepancies between substance use behavior and goals. We’ll be talking more about ambivalence and discrepancy in the next module.
- Summarizing is also a good way to review previous sessions and to end a current counseling session. Summarizing is useful for group sessions as well as individual sessions. It is also a good link between the last session and the current one.
- Summarizing can:
 - Affirm the progress a client or group is making;
 - Remind clients of any commitments they have made; and
 - Reinforce homework assignments.

- For example, a counselor could summarize both a client's report and a session something like this:

We covered a lot of ground today, Richard. We talked about the great success you had in saying "no" to your brother's offer of cocaine. Although it felt really frustrating at the time, you ended up feeling good about yourself afterwards. Did I get that right? We also talked about some problems you're having with time management, and you agreed to write down a schedule for the next week and see how that works for you.

- Notice that in that example the counselor asks, "Did I get that right?" When summarizing, it's important that the counselor encourage the client to correct the summary. In this case, for example, Richard might respond: "It wasn't frustrating, exactly, but I felt kind of guilty because my brother felt bad when I walked away."
- Summarizing also serves a strategic purpose: in presenting a summary, the counselor can select what information to include and what to minimize or leave out. In this way he or she can reinforce the positives and minimize the negatives.
- For example, Richard may have talked about recovery being "just too hard" earlier in his session, but the counselor did not want to remind Richard of that so left it out of the summary

Counselor Intentionality

- Counselor intentionality means selecting helping behaviors and specific strategies with a clear purpose and direction in mind.
- Research links intentionality with positive treatment outcomes.
- In practice, intentionality means that a counselor plans treatment interventions based on an individual client's situation and needs, including his or her stage of change, level of recovery capital, environmental situation, and so on.
- It also means that a counselor goes into an individual or group counseling session with a clear objective in mind and does not allow a session to take on its own momentum.
- Of course, it is important that a counselor is flexible enough to change direction when it is truly warranted but allowing treatment to meander is not productive.
- "In sum, the intentional counselor is one who learns many helping strategies, continues to accumulate knowledge of human development and related critical issues, and offers clients a relationship in which all possibilities can be explored, examined, and evaluated.

MODULE 4

INTRODUCTION TO MOTIVATIONAL INTERVIEWING

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Content and Timeline

Activity	Time
Introduction to Module 4	15 minutes
Large Group Exercise: the Counseling Skills	15 minutes
Presentation: Core Skills in MI: OARS	5 minutes
Large -group exercise: OARS: Open- and closed-ended questions	10 minutes
Partner exercise: OARS: Affirmations	10 minutes
Large group exercise: OARS: Reflections	15 minutes
Presentation : OARS: Summarizing	5 minutes
Large group exercise: OARS.	30 minutes
Break	
Presentation: The MI Approach & Ambivalence	5 minutes
Large-group Exercise: Ambivalence	20 minutes
Presentation: The Spirit of MI	15 minutes
Partner Exercise: The Spirit of MI	15 minutes
Presentation: The General Principles of MI	10 minutes
Small-group exercise: Five Principles of MI	15 minutes
Presentation: The Four Processes in MI	15 minutes
Lunch	
Presentation: Sustain Talk or Status Quo	10 minutes
Partner Exercise: Sustain Talk or Status Quo	10 minutes
Presentation: Strategies for responding to sustain talk and/or discord	10 minutes
Small Group Exercise: Strategies for responding to sustain talk and/or discord	20 minutes
Presentation: Exploring and eliciting change talk in MI: Preparatory Change Talk	10 minutes
Large Group Exercise: Drumming for Change	5 minutes
Presentation& Exercise: Exploring and eliciting change talk in MI: Mobilising Change Talk (CAT)	15 minutes
Small-group Exercise: Evoking mobilizing change talk (CATS)	15 minutes
Presentation: Strategies for Evoking Change	10 minutes
Small Group Exercise: DARN CAT	10 minutes
Break	

<i>Content and Timeline</i>	
<i>Activity</i>	<i>Time</i>
Presentation: The Motivational Interviewing Ruler	15 minutes
Partner Exercise: The Motivational Interviewing Ruler	15 minutes
Presentation: The Decisional Balance	5 minutes
Partner Exercise: The Decisional Balance	10 minutes
Presentation: Developing a Change Plan	5 minutes
Partner Exercise: Personal Development Plan	10 minutes
Large-group Exercise	15 minutes

Module 4 Goals and Objectives

Training goals

Participants who complete this course will have:

- Have a basic understanding of the theory and key principles of Motivational Interviewing (MI)
- Be able to incorporate and apply MI skills in their current therapeutic work
- Have a working knowledge of how to use the readiness, confidence and importance ruler and use decisional balancing in their work with clients

Learning objectives

Participants who complete Module 4 will:

- Have a basic understanding of Motivational Interviewing (MI)
- Be able to apply the spirit, principles, and core methods of motivational interviewing in their therapeutic interventions with their client
- Describe uses of the readiness, confidence and importance ruler; and
- Describe decisional balancing
- Describe how ambivalence, change talk, sustain talk and discord affect the change process

UTC 4

Basic Counseling Skills
for Addiction ProfessionalsMODULE 4—INTRODUCTION TO
MOTIVATIONAL INTERVIEWING

Module 4 Learning Objectives

Participants who complete Module 4 will:

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- Be able to apply the spirit, principles, and core methods of motivational interviewing in their therapeutic interventions with their client
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- Describe decisional balancing
- Describe how ambivalence, change talk, sustain talk and discord affect the change process

4.2

Stages of Change



4.3

What is Motivational Interviewing (MI)?



“Motivational interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is a conversational style for strengthening a person’s own motivation and commitment to change.”

Miller & Rollnick (2013)

4.4

MOTIVATIONAL INTERVIEWING

WHAT IS IT?

- The focusing, evoking, and planning processes in MI have clear directionality to them
- MI was specifically developed to help clients resolve ambivalence and strengthen their own commitment to change
- MI is a collaborative partnership that respects the client’s autonomy
- The Counselor is a guide and not seen as an expert

WHAT IS IT NOT?

- Identical to Roger’s non-directive Counseling
- A technique or gimmick to make people change
- A panacea or solution to all problems
- Easy to Learn
- Practice as usual
- Coercive or expert orientated
- The Transtheoretical Model of Change (TTM)
- Decisional Balance

4.5

Large Group Exercise: the Counseling skills

- We will now view a video and participants will discuss in a larger group their reflections on the Counseling skills of the nurse.

4.6

WHY MI?

- Evidence-Based
- Kindness with skill
- Effective across populations and cultures
- Applicable to range of professional disciplines
- Effective in brief encounters
- Actively involves people in own care
- Improves adherence and retention in care
- Promotes healthy “helping” role for providers
- Instills hope and fosters lasting change

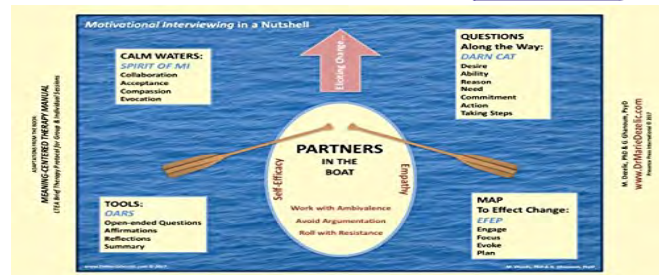
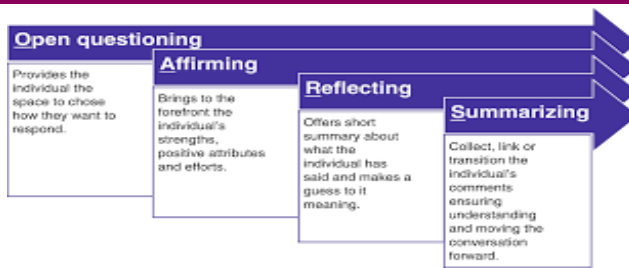
4.7

MI Counseling Skills and Strategies

- The practice of MI involves the skillful use of certain techniques for:
 - bringing to life the ‘*MI spirit*’,
 - demonstrating the MI principles, and
 - guiding the process towards eliciting client change talk and commitment for change.
- Makes use of OARS to establish rapport with the client and move them towards change

4.8

OARS



4.9

OARS

Open-ended questions

Open-ended questions invite the client to discuss issues she/he considers important.

Open-ended questions in MI are intended not simply to elicit information, but also to build forward momentum that will allow the client to explore the reasons for change.



4.10

OARS

Open-ended questions VS Closed questions

To what extent...?

Why...?

What has....?

How...?

Can you tell me about...?

Can you help me understand...?

Did you...?

Do you...?

Will you...?

Can you...?

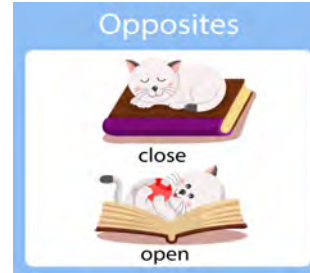


4.11

Large-group Exercise: open- and closed-ended questions

Open-ended questions vs Closed-ended questions.

1. Do you feel that you have a methamphetamine problem?
2. How has your use of drugs affected you?
3. Have you tried to stop drinking before?
4. What are the good things about not drinking?
5. Do you want to be in treatment?
6. How important is the treatment programme for you?



4.12

OARS

Affirmations

Affirmations are statements that acknowledge both the difficulties the client faces, and his or her desire for change.

Affirmations reinforce anything that leads to change and builds the relationship.

Recognition of client's strengths/ positive qualities, achievements, efforts

Eg:

A client reports with a return to substance use and the Counselor responds by saying "You were drug free for six months after treatment and that is a remarkable achievement".

4.13

Partner Exercise : Affirmations

Work in pairs

Remember a time you received a deeply meaningful compliment from someone, you trusted and respected.

Please share this with your partner and if you feel comfortable you can share it with the larger group.

4.14

OARS

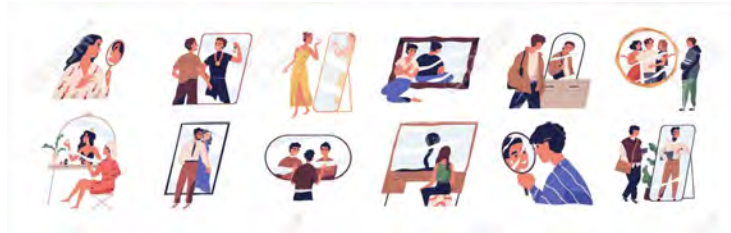
Reflection

Reflections in MI is about re-stating the important content of what the client has said – what he or she is feeling or what he or she means.

Reflections are an opportunity to make sure that the Counselor is in tune with the client.

It presents an opportunity for the client to clarify the understanding of the counselor.

Is a statement and not a question.



4.15

OARS

Universal Safe Reflections

- It sounds like this has been tough for you ...
- It sounds like you are not happy with ...
- It sounds like you are a bit uncomfortable about ...
- It sounds like you're not ready to ...
- It sounds like you are having a problem with ...

4.16

Large Group Exercise : Reflections

We will now do a large group exercise that focuses on practicing reflection skills

Stand up and form a circle in the centre of the room

Invite volunteers to say something that is not too personal (for eg. how your day is so far, or how you felt last night, or what are you excited about)

4.17

OARS

Summarizing

Summarizing states in brief what the client said or has happened earlier.

Sometimes known as, 'long reflection'.

Summarizing can be done before, during and at the end of a counseling session.

Summaries highlight both sides of a client's **ambivalence** about change.

4.18

OARS

Summarizing

Let me see if I understand what you've told me so far...

Ok, this is what I have heard so far...

Follow up with

Ok, how did I do?

What have I missed?

Anything you want to correct?

4.19

Large Group Exercise on OARS

We now watch a video demonstrating the use of OARS. After the video we will discuss your observations and reflections.

4.20

Large Group Exercise

Invite two volunteers

One volunteer is to share their experience in working as Counselors in the addiction treatment field

Take 10 minutes to talk about when you started working, challenges and the good times

The other volunteer is to listen and reflect using OARS

Invite the large-group for their observations

4.21

Break

15 minutes

4.22

The MI Approach

Grounded in a respectful stance with a focus on building rapport in the initial stages of the therapeutic relationship.

Centred around identifying, examining, and resolving **ambivalence** about changing behaviour.

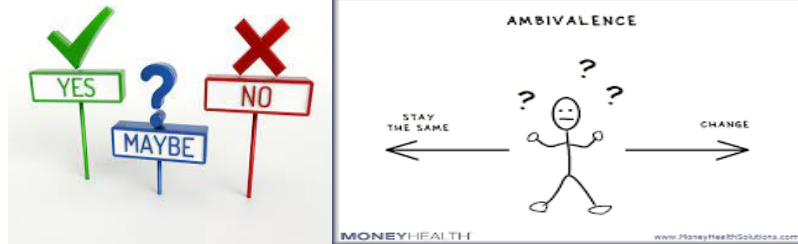
Client's **ambivalence** about change is the **core of the intervention**.



4.23

Ambivalence

Ambivalence (feeling two ways about behaviour change) is seen as a natural path of the change process.



The skilful MI practitioner is attuned to the client's ambivalence and "readiness for change".

4.24

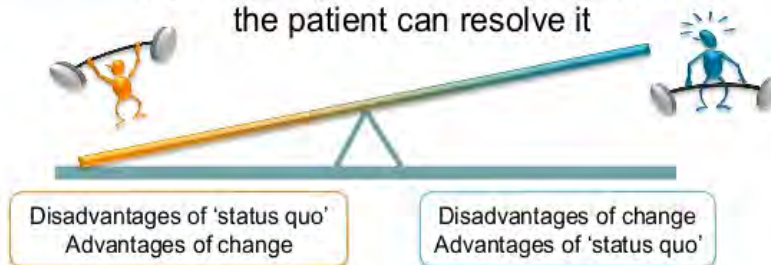
Ambivalence



4.25

Ambivalence

By exploring his or her ambivalence,
the patient can resolve it



4.26

Large-group Exercise - Ambivalence

- Divide the participants into two groups and invite a volunteer to act as a client.
- Group A should stand on one side of the room and Group B should stand on the opposite side of the room.
- The client should stand in the middle between the group A & B. The client should talk about a change that he or she is ambivalent about.
- Group A should argue for one side of the ambivalence (reasons for changing behaviour) and Group B should argue against change (reasons for not changing or maintaining the status quo).

4.27

The “Righting Reflex”

Avoid the righting reflex

Reflex to push someone in the right direction:

- ❑ “Have you considered.....?”
- ❑ “You should try.....”
- ❑ “If you would just....”



4.28

The Spirit of MI: Four Key Elements



4.29

The Spirit of MI

The "Spirit" of Motivational Interviewing

◆ Collaboration	vs.	Confrontation
		
◆ Evocation	vs.	Imposition
		
◆ Autonomy	vs.	Authority
		

4.30

Partner Exercise: A Taste of MI

Role play using the four key elements of the “spirit” of MI to discuss a behaviour that you want to change.

Group into pairs

Ask these questions:

- What would you want to change?
- If you decided to make this change, how might you go about it in order to succeed?
- What are the three best reasons for you to do it?

4.31

General principles of Motivational Interviewing

1. Express empathy
2. Develop discrepancy
3. Support self-efficacy
4. Avoid Argumentation"
5. Sustain Talk & Discord “(formerly Roll with Resistance”)

4.32

The Five Principles of Motivational Interviewing

Principle 1: Express Empathy

The crucial attitude in empathy is one of acceptance.
Empathy involves seeing the world through the client's eyes.
Sharing in the client's experiences.
Active effort to understand the client's internal perspective.



"Can we swap glasses? It might help me to see your point of view!"

4.33

Principles of Motivational Interviewing

Principle 2: Developing Discrepancy

Motivation for change occurs when people perceive a mismatch between where they are and where they want to be.

Clarifies important goals for the client.

Creates and amplifies in the client's mind a discrepancy between their current behaviour and their life goals.



4.34

Principles of Motivational Interviewing

Principle 3: Support self-efficacy

MI is a strengths-based approach that believes that clients have within themselves the capabilities to change successfully.

A client's belief that change is possible (self-efficacy) is needed to instill hope about making change happen.

There is hope in the range of alternative approaches available.



4.35

Principles of Motivational Interviewing

Principle 4: Avoid Argumentation

It is easy to get into an argument especially when the client makes a statement that the counselor believes to be inaccurate or wrong.

MI takes a supportive and strength-based approach. Clients opinions, thoughts and beliefs are explored, reflected and clarified, but not directly contradicted.



4.36

Principles of Motivational Interviewing

Principle 5: Sustain Talk (status quo) and Discord (formerly rolling with resistance)

Sustain Talk relates to target behavior or change
“Eg. “I have more energy to do what I need to do and be a fun mom for my kids when I use cocaine”.

Discord is about the relationship. Eg. “You’re not an addict so you don’t get it.”

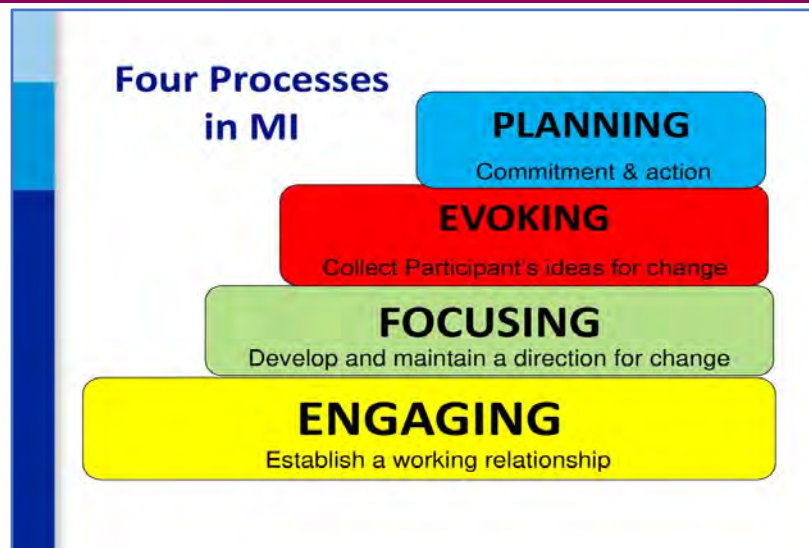
4.37

Small Group Exercise-Five Principles of MI

- Divide the participants into small groups of five.
- One participant in each group should volunteer to be the client while the remaining four participants in the small group will all act as counselors
- The client should role play a difficult client that does not want to be in counseling and is trying to provoke the counselor into an argument
- The four counselors should act as one voice and use the **five principles of MI** that we discussed in dealing with this client

4.38

THE FOUR PROCESSES IN MI



Four Processes in MI

Engaging

Establishing a solid therapeutic relationship is a foundational component of motivational interviewing. Qualities like empathy, acceptance, a focus on client strengths and mutual respect create the foundation for such an alliance.

Engaging also involves four client-centered skills that are abbreviated by the acronym OARS.



4.40

Four Processes in MI

Focusing

Focusing is about helping the client determine what is truly important to him or her and using that information to set the tone for the work.

The goals should, of course, be mutually agreed upon by both client and therapist, but the focus in MI is on encouraging the person to do the work of identifying his or her own area of stuckness, ambivalence or struggle and setting goals accordingly.

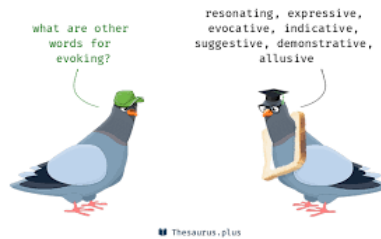


4.41

Four Processes in MI

Evoking

Once a focus has been identified and is mutually agreed upon, evoking involves discovering the client's personal interest in and motivation to change. Being able to recognize when clients say something that suggests they may be willing or ready to move toward change is an important part of the evoking process.



4.42

Four Processes in MI

Planning

The important thing about the planning process in motivational interviewing is that the plan comes from the clients and is based on their unique values, wisdom and self-knowledge. Each of the four processes are geared toward fostering and building the clients' motivation to change, and any attempts on behalf of the counselor to “take the reigns” during the planning process may undermine or reverse the client's sense of empowerment.



4.43

Lunch

60 minutes

4.44

Sustain Talk or Status Quo

- The desire to maintain the status quo (i.e. the client does not want to make changes to his/her behavior).
- Lack of skills to make the changes
- Benefits of the current situation for the individuals
- The need to maintain the status quo (things as they are)



4.45

Discord

Discord is considered as disagreements and disputes that arise in the relationship between the counselor and the client.

It is a noticeably clear sign of lack of harmony in the relationship between the client and the counselor.

Discord is a phenomenon that arises in the relationship between the counselor and client, affecting the therapeutic alliance.

It is a signal that the therapeutic relationship is being negatively affected; therefore, it is very important to detect it quickly.



4.46

When does Discord occur?

It usually arises when the client feels pressured or challenged to take a decision or to carry out any change about which he/she feels ambivalent.

When pressing the client towards the side of change of ambivalence, the client responds by leaning to the other side (status quo or sustain talk)

The usual response of discord is “yes, but.”

4.47

Discord in Clients

Discord in clients may include arguing, interrupting, discounting, defensiveness or ignoring the counselor. Client discord is a sign that the counselor needs to change approach:

- May need to slow down
- Avoid arguing and try to understand what the client is saying and reflect this to client

4.48

Discord in Counselor

Practitioner examples that increase discord:

- Arguing for change: “If you don’t go on medication, your mental health will deteriorate rapidly.”
- Assuming the expert role: “I’ve worked with lots of people like you and I know that you need to...”
- Criticizing, shaming or blaming: “If you just wouldn’t...”
- Labelling the person’s behaviour: “You need to admit that you are an alcoholic.”
- Being in a hurry: “We talked about this last week, shouldn’t we move on to solutions now?”
- Claiming to know what is best for the person: “If you are going to ever recover, you have to...”

4.49

Partner Exercise: Sustain Talk or Status Quo

- Invite two volunteers
- One participant to display discord behaviour of a counselor
- The other participant to play a role of a client
- Take 5 minutes to do a role play

4.50

Strategies for responding to Sustain talk and/or Discord

Shifting Focus

Shifts the client's energy and attention away from obstacles and barriers

Gets around a "stuck" point by simply side-stepping

Client: I can't stop smoking dope when all my friends are doing it.

Counselor: You're way ahead of me; we're not ready to talk about that yet. We're exploring your concerns about your grades and whether you'll stay in school.

4.51

Strategies for responding to Sustain talk and/or Discord

Agreement With a Twist

Agreeing with the client, but with a slight twist or change of direction that propels the discussion forward

Similar to amplified reflection:

Client: “I know I made a mistake, but all of this stuff they’re making me do is ridiculous.”

Counselor: “All of these expectations are frustrating. You’re also anxious to be successful with some things so you can keep moving forward

4.52

Strategies for responding to Sustain talk and/or Discord

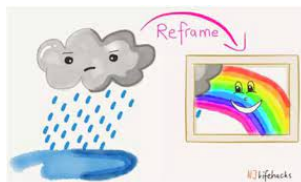
Reframing

Offers a new and positive interpretation of negative information provided by the client.

Acknowledges the validity of the client’s perception, but at the same time offers a new meaning for consideration.

Client: “I know I made a mistake, but all of this stuff they’re making me do is ridiculous.”

Counselor: “You’re not happy about others having so much control, but so far you have been able to keep up with all their expectations and have been quite successful!”



4.53

Strategies for responding to Sustain talk and/or Discord

Emphasizing Personal Choice and Control

- Helps clients recognize that they have, and are making, choices
- Acknowledges the fact that clients do ultimately make their own choices and builds self-efficacy

Client: “I know I made a mistake, but all of this stuff they’re making me do is ridiculous.”

Counselor: “You don’t like what others are asking you to do, but so far you are choosing to follow through with what they are asking. It takes a lot of fortitude to do that.”



4.54

Small Group Exercise - Strategies for Responding to Sustain Talk & Discord

- Divide into two groups
- Provide the assigned topic to each group to explore and to brainstorm the solution
- Identify a reporter from each group to report back to the group.
- Take 10-15 minutes for the discussion

4.55

EXPLORING AND ELICITING CHANGE TALK IN MI : Sustain Talk vs Change Talk



Sustain Talk **Change Talk**

Ambivalence

Listening Strategically:
Change Talk vs. Sustain Talk

Change Talk - words that favor moving in the direction of change

Sustain Talk - words that favor leaving things the way they are

Ply House Lindner Center of HOPE

4.56

Sustain Talk

Sustain talk is the opposite of change talk.

It is a person's argument against change

Sustain talk is associated with maintenance of the status quo

While **change talk** consists of words that favour moving in the direction of change, **sustain talk** consists of words that favour leaving things the way they are.



4.57

Sustain Talk

Sustain Talk: The Reverse DARN CAT

Desire: I like my alcohol

Ability: I don't see how I can give up drinking

Reason: When I drink I feel free and able to handle life's issues

Need: I need to drink to keep me sane

**Yes,
but...**

Commitment: Nobody can stop me. I will drink, as much and when I want

Action: I'm not ready to stop drinking

Taking Step: I started drinking again this week



4.58

Change Talk

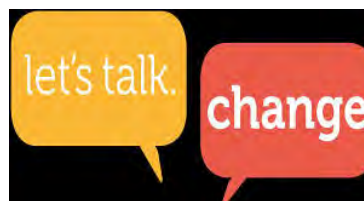
Change talk is any speech that leads to a client wanting to change.

It's when a client expresses in his/her own words that they want to change their current behavior.

Change talk is further categorised into:

Preparatory Change Talk

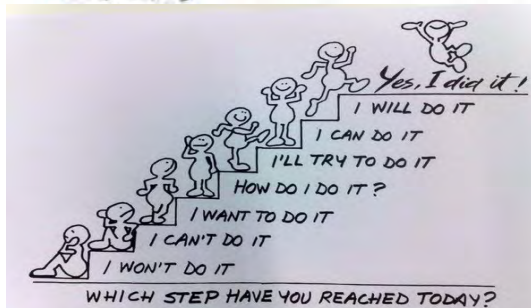
Mobilizing change Talk



4.59

Change Talk

Listen for "Change Talk"



4.60

Preparatory Change Talk

Desire

"I love..."
"I hate..."
"I would like..."

Ability

"I can..."
"I'm not able to..."

Reasons

"This would help me to..."
"I have to because..."

Need

"I have to..."
"I can't go on like this..."



<https://miforquitting.wordpress.com/change-talk/>

4.61

Preparatory Change Talk

Desire – Desire indicates wanting and wanting is a part of motivation for change. It is helpful if patients want to change their behavior. However, patients can and do make behavior changes that they don't want to do. Typically, these statements do not include commitment language.



4.62

Preparatory Change Talk

- **Ability** – This includes the patient's perception that they can achieve the behavior change. When a patient makes statements indicating that they have the ability to make a change it signals that they think the behavior change is possible.
- Typically, these patient conversations can include statements about a patient's ability to change their behavior as well as how to change the behavior.
- These statements tend to end before commitment to change a behavior is expressed.



shutterstock.com - 1866282043



4.63

Preparatory Change Talk

- **Reasons** – This is when the patient states a specific reason for changing their behavior. These statements reveal that the patient sees a specific reason why the behavior change would be advantageous.



4.64

Preparatory Change Talk

- **Need** – This includes patient recognition that there is a need for behavior change. This includes language that reflects an imperative or urgency to change their behavior.



4.65

Large Group Exercise: Drumming for Change Talk

Drumming for Change Talk

1. I think I am doing about as well as I can at this point.
2. I certainly don't want to lose my job.
3. I have just always disliked exercise.
4. I really hate feeling hung over!
5. Well, I wouldn't mind cutting down on stress in my life.
6. I probably could exercise more.
7. Yes, I am going to take my medication every day.
8. It's really hard to stay away from drugs when all my friends are using it around me.

4.66

Exploring and Eliciting Change Talk in MI: Mobilising Change Talk (CAT)

Mobilizing Change Talk

Mobilizing change talk signifies that the client is moving towards resolution of the ambivalence in favour of change.

Commitment	"I will..." "I'm going to..."
Activation	"I'm willing to..." "I'm prepared to..." "I'm ready to..."
Taking Steps	"I did..." "I started by..."

Mobilizing Change Talk



Signals movement resolving ambivalence:

Commitment- intention to act

Activation- willing, ready, prepared to act.

Taking Steps- action is underway.



4.67

Small-group Exercise: Evoking Mobilizing Change Talk

- **Small Group Exercise: Evoking mobilizing change talk (CATS)**
- **Form groups of three and identify an interviewer, a speaker and an observer.**
- **Interviewer is to ask** "What have you learned in this workshop that you can put into practice." using MI Skills to evoke change talks?.
- **Observer is to observe the conversation.**
- **Take turns to allow everyone a chance to practice.**

4.68

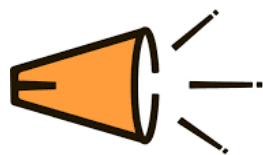
Strategies For Evoking Change Talk

1. Ask Evocative Questions

■ Ask open question used in the “spirit” of MI.

■ Examples:

- ▣ Why would you want to make this change? (D)
- ▣ How might you go about it, in order to succeed? (A)
- ▣ What are the 3 best reasons for you to do it? (R)
- ▣ How important is it for you to make this change? (N)
- ▣ So what do you think you will do? (C)



**EVOKING
CHANGE
STUDIO**

4.69

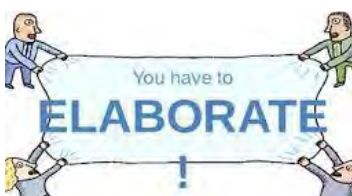
Strategies For Evoking Change Talk

2. Ask for elaboration

- When a change talk theme emerges, ask for more detail.

3. Ask for examples

- When a change talk theme emerges, ask for specific examples



4.70

Strategies For Evoking Change Talk

4. Look back

- Ask about a time before the current problem emerged.
- How were things better or different then?

5. Look forward

- Ask what might happen if things continue as they are.
- If the client was 100% successful in making the changes they want, what would be different?
- How does the client see their life in 5 years?



4.71

Strategies For Evoking Change Talk

6. Query Extremes

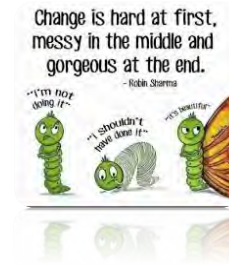
- What are the worst things that might happen if the client does not change/continues current behavior/substance use?
- What are the best things that might happen if the client changes their current behaviour/substance use.



4.72

Small Group Exercise : DARN CAT

- Invite 5 participants to seat close to each other in a row.
- Ask questions to each person
- Each of the five people should answer using the following stem:
 1. Person 1: “I want to”
 2. Person 2: “I could”
 3. Person 3: “I have good reasons to”
 4. Person 4: “I need to”
 5. Person 5 “I will”



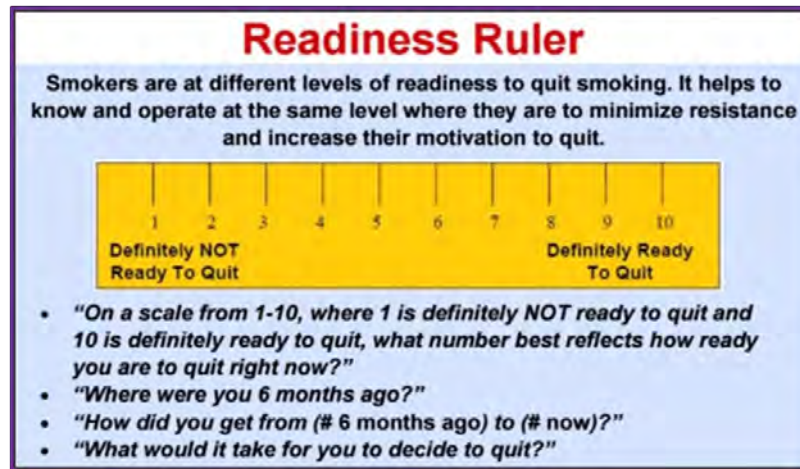
4.73

Break

15 minutes

4.74

THE MOTIVATIONAL INTERVIEWING RULER –



4.75

The Importance Ruler

Importance and Confidence Scale:

Quick and easy ways to talk about Importance and Confidence

Importance

To help me understand how important this is to you, on a scale from 0 to 10, with 0 being not at all important and 10 being very important, how important is it to you to take your pills every evening before bed right now?

0 1 2 3 4 5 6 7 8 9 10

Why are you a __ and not a [slightly lower number]?
Why are you a __ and not a [slightly higher number]?
What would it take for you to move from a __ to a [slightly higher number] ?

4.76

The Confidence Ruler

Importance and Confidence Scale:

Quick and easy ways to talk about Importance and Confidence

Confidence

How confident are you, using that same scale where 0 is no confidence and 10 is very confident, that you could take your pills every evening before bed?

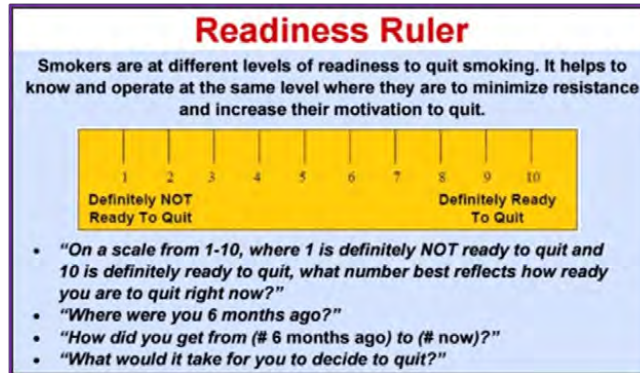
0 1 2 3 4 5 6 7 8 9 10

Why are you a __ and not a [slightly lower number]?
Why are you a __ and not a [slightly higher number]?
What would it take for you to move from a __ to a [slightly higher number] ?

4.77

Partner Exercise : The Motivational Interviewing Ruler

- Divide the participants into pairs
- Practice the readiness, confidence and importance ruler on Zak



4.78

Decisional Balance

The process of appraising or evaluating the "good" aspects of substance use—the reasons not to change, and the less good aspects—the reasons to change

Helping a client recognize and weigh negative aspects of substance use so that the scale tips toward positive change

Helping a client move from external motivation to internal motivation



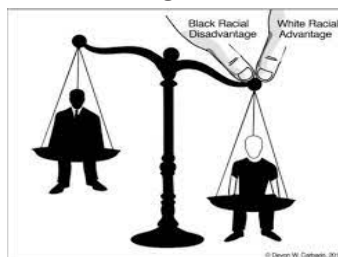
4.79

Goals of Decisional Balance

Helping a client recognize and weigh negative aspects of substance use so that the scale tips toward positive change

Helping a client move from external motivation to internal motivation.

Conscious linking of negative aspects changes a person's perception of a situation "so that a broad pattern of dissatisfaction and shortcoming is discerned."



4.80

Partner Exercise: Decisional Balance

Decisional Balance Sheet

	Disadvantages	Advantages
No Change		
Change		

4.81

DEVELOPING A CHANGE PLAN

When there is a clear goal and plan:

Evoke **activation** talk

“How ready are you to do that? /Are you willing to give that a try?”

Asking for **commitment**

“Is that what you intend to do? /Are you going to do that?”

Getting more **specific**

“How would you get ready? /What will you need?”

Setting a **date**

“When could you do that? /When will you be ready?”

Preparing the client

“What would be the first step?”

4.82

DEVELOPING A CHANGE PLAN

Troubleshoot the plan

Do not provide the answers yourself

- ❑ What might possibly go wrong?
- ❑ Which challenges might you foresee?
- ❑ How will the client respond to them?

Developing a plan from scratch:

- ❑ Keep the process collaborative
- ❑ Provide different suggestions and information (with permission)
- ❑ Elicit, provide, elicit



4.83

Partner Exercise: Personal Development Plan

Following from the previous exercise where you were asked to complete a decisional balance worksheet, you will now draw up your own development plan.

Find a partner and take turns to draw up your development plan based on our discussion.



4.84

Cheat Sheet

Cheat-sheet

Opening strategies

1. Opening strategy: lifestyle, stresses and substance abuse
2. Opening strategy: health and substance abuse
3. A typical using day/session
4. Pros and cons of substance use
5. Providing information
6. Future and present
7. Exploring concerns
8. Helping with decision making



5 Principles of MI

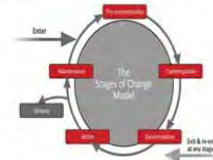
1. Express empathy
2. Develop discrepancy
3. Support self-efficacy
4. Avoid argumentation
5. Sustain talk & discord

Responding to/Evoking change talk

- Ask evocative questions
- Ask for elaboration
- Ask for examples
- Look back
- Look forward
- Query extremes
- Change ruler

OARS

- Open questions
- Affirmations
- Reflections
- Summaries



4.85



4.86

Reflective Exercise

- What did you hear that was new to you?
- How do you think it relates to your practice?



4.87

O.A.R.S

O: Asks mostly open-ended questions (**ahh**)

A: Affirms strengths, abilities & efforts (**clap**)

R: Listens reflectively (**snap**)

S: Summarizes the big picture—
highlighting change talk! (**Pat**)

Conversation Flow

1. Open the conversation — **Engage**

- Name
- Role
- Time
- Ask permission

2. Ask open-ended questions

- Invites client to do most of the talking
- Focus on strengths & successes

3. Negotiate the agenda — **Focus**

- Supports autonomy and choice
- Facilitates conversation
- Less is more!

4. Assess readiness to change— **Evoke**

- Supports tailoring
- Invites “change talk”

5. Explore mixed feelings

- Most common stage of change
- Needs to be addressed for sustained change
- Invites “change talk”

6. Ask about “next step” — **Plan**

- Assesses impact of conversation
- Perspective often shifts in the process!

7. Close the conversation

- Show appreciation
- If appropriate, offer recommendation(s)
- Voice Confidence

Invite and
encourage
“change talk”

Ask

Listen

Summarize

The Process of MI

1. Open the conversation (*Engage*)

- Warm, friendly greeting (smile!)
- Name
- Role
- Time
- Agenda
- Seek permission

2. Negotiate the Agenda (*Focus*)

- Show circle chart
- Read what's in each circle: *"In the circles are some topics we might talk about today. They include..."*
- Elicit choice: *"Which of these might you want to talk about today? Or is there something else?"*
- Encourage elaboration: *"How come you picked ___?"*

3. Ask open-ended question(s) (*Evoke*)

- *What concerns, if any, do you have about _____?*
- *If you made a change in this part of your life, how might it benefit you?*

4. Summarize

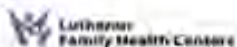
5. Ask about the next step (*"Test the water"*)

- *What's next?*

6. Close the conversation

- **Show Appreciation:** *Thank you!*
- **Voice Confidence:** *I'm confident that if you decide to make a change in this part of your life, you'll find a way to do it!*

Resource Page 4.4: Decisional Balance Sheet



DECISIONAL BALANCE SHEET

Patient name _____ Date completed _____

What are the benefits/pros of alcohol / drug use?	What are the costs/cons of alcohol / drug use?

Importance Rating Scale

On a scale of 1 to 10, with 1 being not important and 10 being very important, how important is it to you to stop drinking/drugging?

Why not a ____? (choose a rating 2 numbers lower and record patient's response) _____

Connections: Co-Occurring Disorders



Motivational Interviewing Skill Foundations



The spirit of Motivational Interviewing is the confluence of Compassion, Acceptance, Partnership & Empathy. The Spirit is the attitude you bring to the people you work with!

OARS

O-Open Ended Questions

Elicit more information. These are questions that will elicit more than a one word response.

A-Affirmations

Shine a light on strengths or efforts, and help clients feel empowered in their ability to change.

R-Reflections

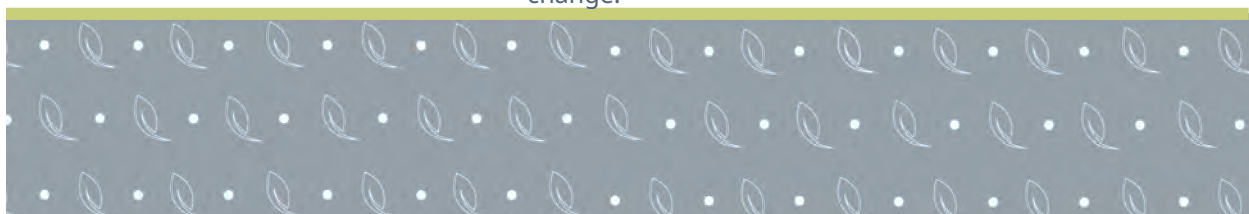
Help the client feel listened to, take conversation deeper & reflect back their motivations for change.

S-Summaries

Consolidate, focus, and guide the conversation toward change.



OARS are the skills we use to metaphorically "row" toward change





The Four Processes of Motivational Interviewing

1. Engaging
2. Focusing
3. Evoking
4. Planning

What process are you in with the client? Are you still *engaging*, developing rapport and safety in the relationship? What is the *focus* of their desired change? Are you *evoking* the client's motivation for change, or imparting your motivation for them? Are they ready to move forward with a change *plan*?

Listen for Change Talk!

What is Change Talk? In essence, it is the *client's* language in favor of change.

Our goal is to elicit change talk, reflect it back, and pull for more.

- To elicit desire for change: "Why would you want to ____?"
- To elicit ability to change: "How might you go about ____?"
- To elicit reasons to change: "What are your reasons for ____?"
- To elicit need to change: "How important is it for you to ____?"

When a client is ready to move into the Planning process, we may evoke commitment change talk:

- To elicit commitment: "What will you do?"
- To elicit action: "What are you considering doing?"
- To elicit steps: "What have you already done?"

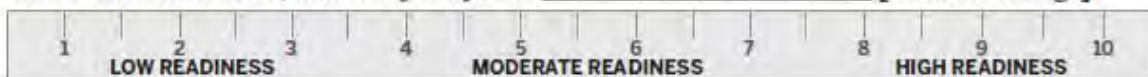
MI Reminders: ● You don't have to come up with all of the answers...ask their ideas first! ● Ask permission before giving advice. ● Strive to provide unconditional positive regard & curiosity for your clients' perspective and the ways *they* can change. ● Keep the responsibility for change in the clients' hands!



Resource Page 4.6: Motivational Interviewing Quick Reference Sheet

Motivational Interviewing Quick Reference Sheet

On a scale from 0 to 10, how ready are you to _____ [behavior change]?



LOW READINESS	MODERATE READINESS	HIGH READINESS
Building Relationships Reflective listening to demonstrate understanding and acceptance Affirmations to appreciate the patient	Building Relationships Reflective listening to demonstrate understanding and acceptance Affirmations to appreciate the patient	Building Relationships Reflective listening to demonstrate understanding and acceptance Affirmations to appreciate the patient
Reflect Resistance/ Demonstrate Acceptance - It sounds like you are not ready to _____ - This is pretty overwhelming Affirm - You are a thoughtful person. - You want to consider all your options. Explore reasons - What would it take for you to move from X to X+1? Provide information or advice with permission - What do you already know about starting [BEHAVIOR]? - May I give you some additional information about [BEHAVIOR]? - May I tell you what some other people in your situation have done? - What do you make of that? (or) - Where does that leave you? Do no harm - That is, don't push so much you trigger resistance. - End on a good note. - Ask for permission to revisit at another meeting.	Elicit Motivation, Explore Ambivalence - Why are you at X and not at 9 or 10? - Tell me more. Reflect, reflect, summarize. - What would need to happen for you to get from X to X+1? - Tell me more. Reflect, reflect, summarize. - If you decided to change, how confident are you that you would succeed? - On a scale from 0 to 10, what number would you give yourself? Strategic open questions - What are the good things (or advantages) of not starting [BEHAVIOR] right now? Reflect, reflect, summarize. - What are the not so good things about not starting [BEHAVIOR] right now? Reflect, reflect, summarize. - Summarize both sides (On one hand..., On the other hand...) - Where does this leave you? Moving toward action with key question - Summarize both sides focusing on change talk. Ask a key question: Where does this leave you now? What is the next step? What, if anything, are you willing to do at this point? If they cannot come up with anything, you may ask permission to give advice - Give menu of options (include status quo). Have them choose. "no change" should be an option. Do no harm - That is, don't push so much you trigger resistance. End on a good note. Ask for permission to revisit at another meeting.	Action Planning: SMART Goals Specific: What are you going to do? What would it look like? Measurable: How often? How much? Attainable: How confident are you that you can do this? What could help? Realistic: What barriers might make this tough? What can you do? Timely: What day and time of day are you going to do this?

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Module 4—Introduction to Motivational Interviewing - Summary

As we learned in Curriculum 2, change is not linear, and clients may move back and forth between stages, including recurrence, before they get to sustained recovery, or maintenance. Just to recap: the stages of change are precontemplation, contemplation, preparation, action, maintenance, and recurrence (relapse).

Treatment and recovery are ultimately about change, so having some specific change strategies in your repertoire is important, no matter what overall treatment model or approach you use.

It is a common misconception that MI is based on the Transtheoretical Model of Change (TTM.) However, both theories were developed in the 1980's (Miller & Rollnick, 2009). According to Miller and Rollnick (2009), development of the TTM helped to create the understanding that most people in SUD treatment are not yet committed to change, and debunked the myth that patients lack the motivation needed for change. While the TTM was not the basis for the development of MI, the TTM provides the conceptual model of understanding change processes, which is essential for applying MI. MI can be used as an intervention for patients in each of the TTM stages of change (Miller & Rollnick, 2013).

What is Motivational Interviewing (MI)?

- Motivational interviewing (MI) is a collaborative, goal orientated style of communication with particular emphasis on the language of change. It is a person- centered form of guiding and strengthening a person's own motivation and commitment for change for a particular behavior.
- MI is a counseling conversation about behavior change. In this module we will be focusing on risky substance use behavior.
- It is a person-centered approach that is guided by a partnership between the client and practitioner. The practitioner honors the client's autonomy by engaging at the pace of the client. The relationship is collaborative and not a top-down, expert-recipient approach.
- The approach focuses on the practitioner evoking the client's own personal motivation and commitment for behavior change.
- The difference between the information/coercive model (treatment as usual) and the MI model
 - The informative/coercive model is an approach that most practitioners are trained in. This process is an expert-recipient approach where advice is given and attempting to persuade the client to make behavior changes.

⁷Miller & Rollnick (2013). *Motivational Interviewing: Helping People Change*. New York: Guilford Press.

- Information and advice are repeated and considered to be the best and only approach to make the changes. This model wants the client to make behavior changes quickly.
 - The MI model is different in that the approach is collaborative, attempting to stimulate the client's own motivation for change. The practitioner tries to listen and understand the client with empathy. The practitioner summarizes the client's points of view and the relationship proceeds step by step as a partnership.
 - MI is not a panacea or solution to all behavioral problems.
 - The Transtheoretical Model of Change is not an essential part of MI as has been inaccurately assumed by many.
- MI is an evidence-based approach that has been shown to be effective globally and with various cultures and populations.
 - Was initially used in risky substance use but can now be applied to a range of various health challenges across professional disciplines.
 - MI can also be used in brief interventions.
 - MI has been shown to improve adherence and retention in treatment programmes.
 - MI has been shown to promote health providers as guiding and with a 'helping' role.
 - MI has been shown to instill hope and fosters longer lasting commitment to change.
 - The practice of MI involves the skillful use of certain techniques for:
 - bringing to life the 'MI spirit',
 - demonstrating the MI principles, and
 - guiding the process towards eliciting client change talk and commitment for change.
 - MI makes use of the OARS counseling skills and MI strategies to bring about the Spirit of MI, to assist in demonstrating the 5 principles of MI and to guide the practitioner towards conversations eliciting change talk and commitment to change by the client.

Core skills in MI: OARS

- OARS are fundamental counseling skills in MI that are vital in engaging the client throughout the four processes of MI. These counseling skills make use of open-ended questions, affirmations, reflective listening, and summarizing (OARS).
- These skills have been discussed in Module 3 in detail so in this module we will just briefly review these skills to refresh your memory. OARS is used throughout the counseling process, and you will see this as we go through this module.
- Additional information can be found in Resource Page 4.1 For a pocket guide for using OARS.

Open-ended questions

- Open-ended questions invite the client to discuss issues she/he considers important
- Open-ended questions in MI are intended not simply to elicit information, but also to build forward momentum that will allow the client to explore the reasons for change. It also facilitates the element of collaboration and allows for gaining a deeper understanding of the client's circumstances and experiences,. This deeper understanding of the clients' perspectives will ideally foster the practitioner's capacity for feeling and expressing empathy. It is important to use open-ended questions in MI instead of closed-ended questions.
- Examples:
 - What brings you here today?
 - How was your stay at the treatment facility?
 - How was your drinking during the past week?
- Below table gives ideas of words to use to ensure the use of open-ended questions as opposed to closed-ended questions.

Open-ended questions	VS	Closed questions
To what extent...?		Did you...?
Why...?		Do you...?
What has....?		Will you...?
How...?		Can you...?
Can you tell me about...?		
Can you help me understand...?		

Affirmations

- Affirmations are statements that acknowledge both the difficulties the client faces, and his or her desire for change.
- Affirmations reinforce anything that leads to change and builds the relationship. Recognition of client's strengths/ positive qualities, achievements, efforts It's a key element in facilitating and supporting self-efficacy.
- Affirmations help clients feel that change is possible even when previous efforts have been unsuccessful. For example: A client reports with a return to substance use and the Counselor responds by saying "You were drug free for six months after treatment and that is a remarkable achievement".

Reflection

- Reflections in MI is about re-stating the important content of what the client has said, or what he or she is feeling, or what he or she means.
- It presents an opportunity for the client to clarify the understanding of the practitioner.
- It's a statement and not a question.
- Affirms and validates the client.
- Keeps the client thinking and talking.
- Reflections are an opportunity to make sure that the Counselor is in tune with the client. It is a key element in facilitating the principle of expressing empathy.
- Reflection is a crucial skill in MI. The purpose of reflection is to bring to life the principle of expressing empathy. The above are examples of general and universal reflections that can be used on all clients. We discussed reflections in detail in the previous module, this is just to refresh your memory.
- Example:
 - It sounds like this has been tough for you ...
 - It sounds like you are not happy with ...
 - It sounds like you are a bit uncomfortable about ...
 - It sounds like you're not ready to ...
 - It sounds like you are having a problem with

Summarizing

- Summarizing states in brief what the client said or has happened earlier.
- Sometimes known as, 'long reflection'.
- Summarizing can be done before, during and at the end of a counseling session.
- Summaries highlight both sides of a client's ambivalence about change.
- Examples
 - Let me see if I understand what you've told me so far...
 - Ok, this is what I have heard so far...

Follow up with

- Ok, how did I do? What have I missed?
- Anything you want to correct?
- Remember that summaries highlight both sides of a client's ambivalence about

change, and it promotes the development of discrepancy. This occurs by strategically selecting what information should be included and what can be minimized or excluded and presenting the information back to the client

The MI Approach and Ambivalence

- Along with the fundamental processes, the MI approach is grounded in a respectful stance with a strong focus on building rapport in the therapeutic relationship. The therapeutic engagement is important throughout the MI conversation.
- **Ambivalence** is the core of the intervention, practitioners need to focus on identifying, examining and resolving the ambivalence in partnership with the client.
- Ambivalence is feeling two ways about behavior change. It is a mix of change talk and sustain talk. Ambivalence is progress and clients are seen at the contemplation of readiness to change stage.
- When ambivalence is present in the conversation, it means that the client is in conflict with the dilemma of having thoughts of both change talk and sustain talk. The practitioner can respond to ambivalence by using the spirit of MI as well as engage the client using the counseling skills to converse around preparing and mobilizing towards change talk.
- The spirit of MI and change talk will be discussed in more depth throughout this training
- In a person who is facing ambivalence, emotions or attitudes coexist, that are often contradictory or difficult to reconcile, which causes tension. This is common in people, especially in situations in which they have more than one course of action to follow, that is, different alternatives from which they must choose one. By exploring the ambivalence, the client can hopefully resolve it.
- It is a natural inclination we have to make it better for the next person. In the engaging process with clients, practitioners need to avoid the 'righting reflex'. One needs to avoid wanting to solve and fix the problems or challenges for the client.
- What's the danger? We tell the other person what to do, how to do it, and why they should do it without talking to them and learning what they think. This can create discord in the client as we are moving away from a collaborative partnership to an expert top-down role

The Spirit of MI: Four Key Elements

- There are four elements that make up the 'spirit' of MI. These are collaborations partnership, acceptance, compassion and evocation.
- MI is a partnership between counselor and client and is collaborative in nature. MI is done 'for' and 'with' a client and the conversation is in collaboration with each other rather than a confrontation. The partnership is about understanding the client's experiences with empathy and seeing it through their point of view. Other therapeutic approaches are often confrontational when discussing risky substance use behaviors.

- Acceptance is about accepting what the client brings to the therapeutic relationship. By accepting a client's worth and by displaying accurate empathy and affirming the client's strengths and efforts, the practitioner of MI supports a client's autonomy.
- Evocation is drawing out the client's own ideas, thoughts and motivation for behavior change related to risky substance use. It is also drawing out their own strengths and skills for behavior change. It is not about imposing your thoughts and ideas as the practitioner.
- Being compassionate is to promote the welfare of your client by prioritizing their needs and by engaging them empathetically in a non-judgmental, non-blaming and non-shaming way. The therapist needs to understand what it is like for the client and what it means for them.
- Motivational Interviewing is not just about techniques, it is also about the heart and mindset with which one engages. MI is characterized by the 'spirit' or 'way of being' in the context of the therapeutic relationship within which the techniques of MI are employed.
- MI is a guiding style whereby the practitioner skillfully guides the client using OARS and also offers expert advice. The responsibility for behavior changes ultimately lies with the client.

General principles of Motivational Interviewing

- There are 5 basic principles that motivational interviewing is founded on. These are
 1. Express empathy
 2. Develop discrepancy
 3. Support self-efficacy
 4. Avoid Argumentation"
 5. Sustain Talk & Discord "(formerly Roll with Resistance").

Principle 1: Express Empathy

- The crucial attitude in empathy is one of acceptance. Empathy involves seeing the world through the client's eyes. Sharing in the client's experiences.
- Active effort to understand the client's internal perspective
- Empathy is NOT...
 - Feeling sorry for someone.
 - Having had the same problem or experience and discussing it.

⁸Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford Press.

- Identification with the person. Empathy IS...
- The ability to accurately understand the person's experiences and circumstances – "Accurate Empathy"
- The ability to reflect that accurate understanding back to the client to ensure that the client feels listened to and understood.
- Empathy involves seeing the world through the client's eyes.
- Thinking about things as the client thinks about them.
- Sharing in the client's experiences

Principle 2: Developing Discrepancy

- MI works to develop this by helping the client examine the discrepancies between their current circumstances/behavior and their values and future goals. Some areas to discuss include health, family/relationships, career/employment.
- It is triggered and developed by assisting the client to become aware of the costs of their current behavior.
- Motivation for change occurs when people perceive a mismatch between where they are and where they want to be.

Principle 3: Support self-efficacy

- MI is a strengths-based approach that believes that clients have within themselves the capabilities to change their behavior successfully.
- A client's belief that change is possible (self-efficacy) is needed to instill hope about making change happen. It is important for the practitioner to support the client's self-efficacy and evoke ideas from the client around change.
- Focuses on previous successes and highlight skills and strengths that the client already has.
- It is important for the practitioner to have belief in the client's ability to change and support their self-efficacy.

Principle 4: Avoid Argumentation

- It is easy to get into an argument especially when the client makes a statement that the counselor believes to be inaccurate or wrong.
- MI takes a supportive and strength-based approach. Clients' opinions, thoughts and beliefs are explored, reflected and clarified, but not directly contradicted.

Principle 5: Sustain Talk (status quo) and Discord (formerly rolling with resistance)

- For many years, the concept of resistance management has been used to address the person who presented with ambivalent and challenging behavior. A simple definition

of the concept of Ambivalence is “mixed feelings”. In other words, people often want to change and don’t want to change, both at the same time. When listening to a person who is ambivalent about change, we will most likely hear comments related to their desire/ interest/need to change, combined with some comments that are specific to the sustain talk.

- Miller and Rollnick Motivational Interviewing model used the concept of resistance to refer to the individual’s behavior which take him/her away from change. This concept entrusts all responsibility for this phenomenon to the person, focusing on his/her pathology and underestimating the interpersonal determinants (Miller, W.; Rollnick, S; (2013) *Motivational Interviewing, Helping People Change*-The Guilford Press). In their most recent papers, they have deconstructed the concept of resistance into two components. On one hand, the Sustain Talk or Status Quo: the motivations and verbalizations of the person served to maintain the status quo, which is only one of the faces of ambivalence. The other component is Discord, which we will review in the following slides, and which refers to the verbal disagreements that arise between the counselor and the person served during conversation.

The Four Processes In MI

- There are essential elements to Motivational Interviewing, with four overlapping fundamental processes taking place in the interview process. The four processes in MI are engaging, focusing, evoking and planning. Each process takes place in a different stage of the conversation. We will be practicing these four processes throughout this module.
 - Engaging: To establish a working/therapeutic relationship using counseling skills. Engagement can occur within minutes or take much longer to establish and maintain.
 - Focusing: Develop and maintain focus in a direction of risky substance use behavior change. It is about the process of becoming clear about goals and direction in MI.
 - Evoking: Bring forth the client’s own ideas/strengths for behavior change. The evoking process is intended to help resolve ambivalence in the direction of change.
 - Planning: Once ready to change, the client needs to commit and formulate a plan of action.
- Please see Resource Page 4.2 and Page 4.3 for a summarized worksheet of the four Processes of MI that the counselor can use as a quick reference guide.

1. Engaging

- Establishing a solid therapeutic relationship is a foundational component of motivational interviewing. Qualities like empathy, acceptance, a focus on client strengths and mutual respect create the foundation for such an alliance.
- Engaging also involves four client-centered skills that are abbreviated by the acronym OARS.

2. Focusing

- Focusing is about helping the client determine what is truly important to him or her and using that information to set the tone for the work.
- The goals should, of course, be mutually agreed upon by both client and therapist, but the focus in MI is on encouraging the person to do the work of identifying his or her own area of stuckness, ambivalence or struggle and setting goals accordingly.

3. Evoking

- Once a focus has been identified and is mutually agreed upon, evoking involves discovering the client's personal interest in and motivation to change. Being able to recognize when clients say something that suggests they may be willing or ready to move toward change is an important part of the evoking process.

4. Planning

- The important thing about the planning process in motivational interviewing is that the plan comes from the clients and is based on their unique values, wisdom and self-knowledge. Each of the four processes are geared toward fostering and building the clients' motivation to change, and any attempts on behalf of the counselor to "take the reigns" during the planning process may undermine or reverse the client's sense of empowerment.

Sustain Talk Or Status Quo

- Sustain talk or Status quo include the following kind of motivations by the person served:
 - The desire to maintain the Status quo (i.e., the person served does not want to make changes to his/her behavior).
 - Lack of skills to make changes.
 - Benefits of the current situation for the individual.
 - The need to maintain the Status quo (things as they are)
- Discord is considered as disagreements and disputes that arise in the relationship between the counselor and the client.
- Discord is experienced when the counselor interrupts the client, does not follow his or her instructions or discredits him/her.
- It is a noticeably clear sign of lack of harmony in the relationship between the client and the counselor.
- Discord is a phenomenon that arises in the relationship between the counselor and client, affecting the therapeutic alliance. It is a signal that the therapeutic relationship is being negatively affected; therefore, it is very important to detect it quickly.

- It usually arises when the client feels pressured or challenged to take a decision or to carry out any change about which he/she feels ambivalent.
- When pressing the client towards the side of change of ambivalence, the client responds by leaning to the other side (status quo or sustain talk)
- The usual response of discord is “yes, but.”
- Discord in clients may include arguing, interrupting, discounting or ignoring.
- Participant discord is a sign that to change approach:
 - Practitioner may need to slow down
 - Practitioner needs to avoid arguing and try to understand what the client is saying and reflect that
- As the practitioner, we have the ability to contribute discord in the therapeutic relationship or we can prevent it.
- The following are discord signals:
 - Defensiveness: we can create defensiveness by challenging and discounting the client.
 - Arguing: this occurs when we do not recognize the sustain talk in the client. We can end up arguing for behavior change which then creates more discord from the client and leads to more arguments.
 - Interrupting: this occurs when the client talks over the practitioner and is no longer collaborating in the therapeutic relationship.
 - Ignoring: this occurs where the client is no longer invested in the therapeutic relationship and no longer pays attention and changes the topic away from the behavior that needs to change.
- Practitioner examples that increase discord:
 - Arguing for change: “If you don’t go on medication, your mental health will deteriorate rapidly.”
 - Assuming the expert role: “I’ve worked with lots of people like you and I know that you need to...”
 - Criticizing, shaming or blaming: “If you just wouldn’t...”
 - Labelling the person’s behavior: “You need to admit that you are an alcoholic.”
 - Being in a hurry: “We talked about this last week; shouldn’t we move on to solutions now?”
 - Claiming to know what is best for the person: “If you are going to ever recover, you have to...”

Strategies for Responding to Sustain Talk and/or Discord

Shifting Focus

- Shifting focus shifts the client's energy and attention away from obstacles and barriers. It's a way of getting around a "stuck" point to keep the client talking and progressing. Sometimes it's best to simply ignore a client's negative statement; other times it's important to briefly acknowledge what the client has said and move on. One way of shifting focus is to be very clear about what you're doing and why.
- For example:
 - **Client:** I can't stop smoking dope when all my friends are doing it.
 - **Counselor:** You are way ahead of me; we're not ready to talk about that yet. We're exploring your concerns about your grades and whether you'll stay in school.
 - At other times, it may be best to simply move on without explanation. For example:
 - **Client:** "I know I made a mistake, but all of this stuff they're making me do is ridiculous."
 - **Counselor:** "You're upset by everything you have to do right now. Can you tell me more about the mistake you think you made?"

Agreement With a Twist

- Agreement with a twist, is a subtle strategy that is similar to amplified reflection. The counselor agrees with the client, but with a slight twist or change of direction that propels the discussion forward. For example, using the same client phrase:
 - **Client:** "I know I made a mistake, but all of this stuff they're making me do is ridiculous."
 - **Counselor:** "All of these expectations are frustrating. You're also anxious to be successful with some things so you can keep moving forward."

Reframing

- Reframing offers a new and positive interpretation of negative information provided by the client. It acknowledges the validity of the client's perception, but at the same time offers a new meaning for consideration. For example:
 - **Client:** "I know I made a mistake, but all of this stuff they're making me do is ridiculous."
 - **Counselor:** "You're not happy about others having so much control, but so far you have been able to keep up with all their expectations and have been quite successful!"
- Education also can be a useful way to use reframing. For example, many heavy drinkers believe they do not have a substance use disorder because they can "hold their liquor." When the counselor explains objectively that tolerance is a risk factor and a warning signal, clients' perspectives may shift regarding the meaning of their ability to hold their liquor.

Emphasizing Personal Choice and Control

- Emphasizing personal choice and control can help clients recognize that they are, in fact, making a choice. Clients ultimately do choose a course of action, and this technique simply acknowledges this fact. For example:
 - **Client:** “I know I made a mistake, but all of this stuff they’re making me do is ridiculous.”
 - **Counselor:** “You don’t like what others are asking you to do, but so far you are choosing to follow through with what they are asking. It takes a lot of fortitude to do that.”
- Acknowledging the positive choices a client makes also helps build his or her feelings of self-efficacy.

Exploring and Eliciting Change Talk In MI

Sustain Talk versus Change Talk

- Very basic definitions include:
 - Change talk is words that favor moving towards making behavior changes.
 - Sustain talk is words that favor not making behavior changes and leaving things the way they are.

Sustain Talk

- Sustain talk is the opposite of change talk. It is a person’s argument against change
- Sustain talk is associated with maintenance of the status quo
- While **change talk** consists of words that favor moving in the direction of change, sustain talk consists of words that favor leaving things the way they are.
- Sustain talk is about the client’s ambivalence about changing their behavior related to risky substance use. They are not in favor of making any changes about the behavior.
 - E.g., “I will never have fun again without drinking.”
- Sustain talk is associated with the maintenance of the status quo or current behavior.
- The more people verbalize and explore sustain talk, the more they talk themselves out of changing.

Change Talk

- Change talk is any speech that is an argument, or self-expressed language, for change.
- It’s when a client expresses in his/her own words that they want to change their current behavior
- It is not always easy to identify as a practitioner, it is at times like digging for gold nuggets. OARS skills and listening skills become important in identifying change talk. There are different types of and indicators of change talk.

- Change talk is further categorized into;
 1. Preparatory Change Talk
 2. Mobilizing change Talk
- In change talk, counselors need to identify any speech that favors change. It is any self-expressed talk by the client that indicates willing to change.
- Preparatory change talk is indicative of pro-change side of ambivalence while mobilizing change talk reflects movement towards resolution of the ambivalence in favor of change.

1. *Preparatory Change Talk*

- Preparatory change talk is labelled as such because each of these types of change talk alone or combined, indicate that a client is thinking about changing their behavior, but are not expressing commitment to do so. However, even though these statements lack commitment they are still important in the MI process.
- Contemplating or preparing for change talk has four subtypes. These types of change talk indicate desire, ability, reasons and need. The type of speech used, will indicate various levels of willingness, motivation and commitment to behavior change.
- Desire indicates wanting and wanting is a part of motivation for change. It is helpful if patients want to change their behavior. However, patients can and do make behavior changes that they don't want to do.
- Typically, these statements do not include commitment language.
- Ability includes the patient's perception that they can achieve the behavior change. When a patient makes statements indicating that they have the ability to make a change it signals that they think the behavior change is possible. Typically, these patient conversations can include statements about a patient's ability to change their behavior as well as how to change the behavior.
- These statements tend to end before commitment to change a behavior is expressed.
- Reason is when the patient states a specific reason for changing their behavior.
- These statements reveal that the patient sees a specific reason why the behavior change would be advantageous.
- Need includes patient recognition that there is a need for behavior change. This includes language that reflects an imperative or urgency to change their behavior.

2. *Mobilizing Change Talk (CAT)*

- Implementing change talk indicates commitment towards changing behavior.
- These are indicated by commitment, intention, activation or talking steps towards change.

- Commitment language signals the likelihood of action. Commitment language is what people use to make promises to each other. Contracts are written in commitment language.
- Activation are words that indicate movement toward action, but not yet a commitment to do it. Language such as: “I am willing to...”, “I am prepared to ...” are examples of activation talk.
- Taking steps is language that indicates that the client has already done something in the direction of change.

Strategies for Evoking Change Talk

1. Ask open question used in the “spirit” of MI.
 - Examples:
 - Why would you want to make this change? (D)
 - How might you go about it, in order to succeed? (A)
 - What are the 3 best reasons for you to do it? (R)
 - How important is it for you to make this change? (N)
 - So, what do you think you will do? (C)
2. Ask for elaboration:
 - When a change talk theme emerges, ask for more detail.
3. Ask for examples:
 - When a change talk theme emerges, ask for specific examples.
4. Look back:
 - Ask about a time before the current problem emerged.
 - How were things better or different then?
5. Look forward:
 - Ask what might happen if things continue as they are.
 - If the client was 100% successful in making the changes they want, what would be different?
 - How does the client see their life in 5 years?
6. Query Extremes:
 - What are the worst things that might happen if the client does not change/continues current behavior/substance use?

- What are the best things that might happen if the client changes their current behavior/substance use?

The Motivational Interviewing Ruler

- The MI Ruler is a helpful tool to support the use of Motivational Interviewing (MI) developed by Stephen Rollnick. Use the ruler with MI skills and principles. The ruler is designed to help clients to:
 - Discover their own motivation in considering and/or making a change related to substance use.
 - Express in their own words their desire for change (change talk)
 - Examine their ambivalence about the change,
 - Plan for and begin the process of change,
 - Elicit and strengthen change talk.
 - Enhance their confidence in taking action.
 - Strengthen their commitment to make changes.
- We know that adopting new behaviors, or changing old ones, can result from motivation (importance) and self-efficacy (confidence) as well as an individual's personal characteristics and social and environmental factors. Exploring these factors with a client allows us to learn about facilitators and barriers and can help us guide the client towards change and make it easier to tailor an appropriate action plan.

The confidence Ruler

- The first question asked:
- "To help me understand how important this is to you, on a scale from 0 to 10, with 0 being not at all important and 10 being very important, how important is it for you to take your pills every evening before bed right now (or insert another topic)?"
- 0 1 2 3 4 5 6 7 8 9 10
- This question allows the practitioner to understand where the client believes they are related to how important it is for them to take their medications. The question is helpful, but it is really the follow-up questions that provides the practitioner with the information that can help us learn about the facilitators and barriers to change.
- If the client selects the number 7 on the scale, the next question could be: Why are you a (7) and not a (3)?

⁹Tobacco 101: A Guide to Working with Nicotine Addicted Patients. Nevin Zablotsky, DMD

¹⁰uncmotivationalinterviewing.wordpress.com/2017/08/21/motivational-interviewing-questions-evoking-change-talk-through-importance-and-confidence-rulers/

- This question allows us to understand what helps the client (facilitators of the behavior) to do this.
- The follow-up question could be:
- Why are you a (7) and not a (9)?
- This allows us to understand what gets in the way for the client (barriers of the behavior) to do this.
- The last question in this sequence could be:
- What would it take for you to move from a (7) to a (9)?
- This allows us to understand what may be included in an action plan for behavior change.
- By using scales like the ones above or creating one that is more appropriate for the client or topic, a great deal of valuable information can be obtained from the practitioner, and much exploration can occur for the client. Try using these scales and let me know how it works, or if you tweak them to make them more useful for you and your client, it would be great to hear about too!

Decisional Balance

- Decisional balance is the process of appraising or evaluating the “good” aspects of substance use—the reasons not to change, and the less good aspects—the reasons to change.
- Helping a client recognize and weigh negative aspects of substance use so that the scale tips toward positive change.
- Helping a client move from external motivation to internal motivation.
- Helping a client recognize and weigh negative aspects of substance use so that the scale tips toward positive change
- Helping a client move from external motivation to internal motivation.
- Conscious linking of negative aspects changes a person’s perception of a situation “so that a broad pattern of dissatisfaction and shortcoming is discerned

Developing a Change Plan

- The planning process in MI is to be with the client while he/she forms a change plan that will work. The counselor helps the client develop a plan that makes sense to the client. The counselor applies all the skills used in MI to help the client develop a change plan.
- These are some of the guiding questions that can be asked of the client in developing the change plan:

- When there is a clear goal and plan:
 - Evoke **activation** talk
 - “How ready are you to do that? /Are you willing to give that a try?”
- Asking for **commitment**
 - “Is that what you intend to do? /Are you going to do that?”
- Getting more **specific**
 - “How would you get ready? /What will you need?”
- Setting a **date**
 - “When could you do that? /When will you be ready?”
- **Preparing** the client
 - “What would be the first step?”
- Troubleshoot the plan:
 - Do not provide the answers yourself. Ask the client the following questions:
 - What might possibly go wrong?
 - Which challenges might you foresee?
 - How will the client respond to them? Developing a plan from scratch:
 - Keep the process collaborative
 - Provide different suggestions and information (with permission)
 - Elicit, provide, elicit

MODULE 5

GROUP COUNSELING: BASIC SKILLS

Content and timeline.	309
Training goals and learning objectives	309
PowerPoint slides	310
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Content and Timeline	
Activity	Time
Welcome, review of day 3 and Introduction to Module 5	15 minutes
Presentation: Preparing clients for groups—Overview	15 minutes
Small-group exercise: Preparing clients for groups	30 minutes
Presentation: General types of groups: Membership, timeline, and focus	15 minutes
Presentation: Phases of group development	15 minutes
<i>Break</i>	<i>15 minutes</i>
Presentation: Structuring a group session	10 minutes
Presentation: Avoiding a leader-centered group	15 minutes
Small-group demonstrations: Group role-plays of process-focused groups	70 minutes
Small-group presentations: Issues in group management—Part 1, preparation	30 minutes
<i>Lunch</i>	<i>60 minutes</i>
Small-group presentations: Issues in group management—Part 2, presentation	50 minutes

Module 5 Goals and Objectives

Training goals

- Provide an overview of the differences between individual and group counseling;
- Provide information on the phases of group development and the roles of group participants; and
- Provide an opportunity for participants to observe and practice basic group facilitation.

Learning objectives

Participants who complete Module 5 will be able to:

- Describe the process of preparing clients for groups;
- Describe at least two basic issues or tasks for each typical group phase;
- Describe a basic way to structure a group session;
- List at least three ways to avoid leader-centered groups; and
- Demonstrate ways of managing disruptive behavior in groups.



UNIVERSAL
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Treatment of Substance Use Disorders

The Universal Treatment Curriculum for Substance Use Disorders (UTC)

UTC 4

Basic Counseling Skills
for Addiction Professionals



MODULE 5—GROUP COUNSELING: BASIC SKILLS



DAP
Drug Advisory Programme

Important

- Group counseling is **not** the same thing as doing individual counseling in a group setting!
- Listening and responding skills are required to engage with individual members and work with the group as a whole
- The needs of the group as a whole must be balanced with the needs of individuals in the group
- Group counseling includes good facilitation skills that enable the group to do most of the work

5.2

Module 5 Learning Objectives

- Describe the process of preparing clients for groups
- Describe a basic way to structure a group session
- Describe a basic structure of a group session
- List at least 3 ways to avoid leader-centered groups
- Demonstrate ways of managing disruptive behavior in groups

5.3

Preparing Clients for Group

- Preparing clients for group work:
 - ▣ Helps groups become more therapeutic more quickly
 - ▣ Has a positive effect on client improvement



5.4

Special Considerations

- Not all clients are right for a group:
 - ▣ Clients with co-occurring mental disorders (e.g., severe depression; anxiety) may not be able to function well in a group setting
 - ▣ Clients with a co-occurring personality disorder may need a group with very strict boundaries to avoid a negative group experience or to avoid negatively affecting other group members
- Each client must be assessed for his or her own individual needs in treatment

5.5

Preparing Clients for Group Work (continued)

■ Recognize and affirm clients' expectations

- ▣ Ask about expectations
- ▣ Correct any misconceptions
- ▣ Affirm positive expectations
- ▣ Address and reframe fears



5.6

Goals of Preparation

- Establish a preliminary alliance between client and counselor
- Gain a clear mutual understanding about the client's expectations
- Offer information and instruction about the group

5.7

Goals of Preparation (continued)

- Deal with initial client anxiety about joining a group
- Present and gain acceptance of a group agreement

5.8

Preparing Clients for Group Work (continued)

■ Group agreements

- ▣ Attendance requirements
- ▣ Expectations of confidentiality
- ▣ Whether physical contact is okay
- ▣ Use of substances
- ▣ Minimum participation requirements
- ▣ The counselor's punctuality

5.9

Special Considerations (continued)

- Not all clients are right for a group:
 - ▣ Clients who have experienced trauma, especially sexual abuse, may need a homogeneous group
 - ▣ Clients in the throes of a life crisis may require more concentrated attention than groups can provide
 - ▣ Clients who choose not to participate in group therapy should not be criticized or penalized

5.10

Preparing Clients for Group Work

- Screen clients for appropriateness
 - ▣ Assess ability to function in group
 - ▣ Assess stage of change
 - ▣ Assess willingness to participate

5.11

Preparing Clients for Group Work (continued)

■ Provide information:

- ▣ How group counseling compares with other group experiences clients may have had
- ▣ The benefits of group counseling, or how group might specifically help the client
- ▣ How the group is structured
- ▣ The kinds of issues the group addresses

5.12

Pre-group Meetings With Clients

- Clarify expectations
 - Of the client
 - Of the treatment program
- Set up basic ground rules
- Explore the advantages of group therapy
- Correct any misconceptions about groups

5.13

Assessing and Matching Clients to Groups

- Consider:
 - The client's characteristics, needs, preferences, stage of change, and stage of recovery
 - The program's resources
 - The nature of the group or groups available

5.14

Small-Group Exercise: Preparing Clients for Groups

- Resource Page 5.2: Potential Group Members: Client Profiles
- Resource Page 5.3: Types of Groups
- For *each* of your three assigned clients:
 - ▣ Which group is *most* appropriate?
 - ▣ Why?
 - ▣ How will you prepare the client for the group?
- For *one* client, develop a role-play demonstrating preparing the client for group

5.15

General Types of Groups: Static Versus Revolving Membership

- *Static* membership groups keep the same membership throughout the life of the group with no new people joining
- *Revolving* membership groups have people come and go, join and leave, and the group continues on despite the changing membership

5.16

General Types of Groups: Time-Limited Versus Ongoing

- Time-limited groups have a set number of sessions (an education group is a good example)
- Ongoing groups have no specific end date

5.17

General Types of Groups: Content-Oriented Versus Process-Oriented Groups

- Content-oriented groups focus on identified topics for each session (for example: education or skills-training groups)
- Process-oriented groups focus on the interaction between group members and counselors and are “here and now” focused, with no specific topic identified for each session

5.18

Your Agency's Groups

- Membership: static or revolving?
- Timeline: Time-limited or ongoing?
- Focus: Content-oriented or process-oriented?

5.19

Phases of Group Development

- Beginning phase
- Middle phase
- End phase

5.20

Beginning Phase Issues and Tasks

- Introducing members and facilitators
- Establishing/reviewing a group agreement
- Providing a safe, cohesive environment
- Establishing norms
- Initiating the work of the group

5.21

Middle Phase Issues and Tasks

- Balancing content and process
- Noticing and rolling with resistance
- Keeping the group focused
- Modeling a healthy interactional style
- *Facilitating* rather than running or directing the group

5.22

End Phase Issues and Tasks

- Putting closure on the experience
- Examining the impact of the group on each person
- Acknowledging the feelings triggered by departure
- Giving and receiving feedback about the group experience and each member's role in it
- Completing any unfinished business
- Exploring ways to carry on the learning

5.23

Break

15 minutes

5.24

Structuring a Group Session (continued)

- By structuring a group session:
 - ▣ The facilitator ensures that important aspects of the work are protected
 - ▣ Group members know what to expect from a session
 - ▣ Beginning and ending rituals are established



5.25

Structuring a Group Session (continued)

- Opening and welcome
- Verification
- Review group norms and rules
- Active work
- Summary and homework
- Closing

5.26

Opening and Welcome

- Greet each participant warmly
- Begin the session ON TIME!
 - ▣ Beginning on time sends the message that the work of the group is important
 - ▣ A late group leader sends the message that the group is not important and conveys a lack of respect for participants' time
 - ▣ Waiting for late group members reinforces lateness and conveys lack of respect for group boundaries and participants

5.27

Opening and Welcome (continued)

- Introduce new members
- Provide information and announcements
- Opening ritual

5.28

Verification

- Review of last session
- Homework follow up
- “How are you all feeling today?”

5.29

Active Work

- The heart of the session
- Content-oriented or process-oriented, depending on type of group



5.30

Summary and Homework

- Summarize the work of the group or ask the group to summarize
- Give or reinforce homework assignments
- Affirm the work of the group
- Ask the group for any other affirmations
- Check in with participants if necessary

5.31

Closing

- Closing ritual
 - ▣ For example: Asking group members what was learned that they are taking away from the group

5.32

Leader-centered Groups

- Content-oriented group
 - ▣ For example: Psychoeducational groups
 - ▣ Leader becomes a teacher
- A process group that remains leader-centered:
 - ▣ Limits the potential for learning and growth
 - ▣ May include one-on-one counseling in the group
 - ▣ Does not use the full power of the group to support experiential change or to build authentic, supportive interpersonal relationships

5.33

Group Facilitation

- The practice of supporting a group's process rather than creating or directing it

5.34

Group Facilitation (continued)

- Avoid doing for the group what it can do for itself:
 - ▣ Turn questions back over to the group
 - ▣ Ask a group member to direct a comment to another group member
 - ▣ Don't always be the one to break a silence
 - ▣ Ask the group to comment on process

5.35

Group Facilitation (continued)

- Teach participants to support one another:
 - ▣ Model support in early stages of group
 - ▣ Teach specific skills
 - ▣ Reinforce and affirm participants' support of one another
 - ▣ *Don't* rush in to offer support to a participant in the later stages of group

5.36

Emotional Contagion

- Another's sharing can stir frightening memories and intense emotions in listeners
- Emotional contagion can overwhelm group members and the group process



5.37

Emotional Contagion (continued)

- To prevent or counter emotional contagion, the facilitator needs to:
 - Protect individuals
 - Protect boundaries
 - Regulate emotionality

5.38

Protect Individuals

- Guard the right of each member *not* to be involved in emotional discussions:
 - ▣ Make it clear that each group member has a right to private emotions and feelings
 - ▣ When the group pressures a member to disclose information, remind the group that members need reveal information about themselves only at levels with which they are comfortable

5.39

Protect Boundaries

- Clarify that each client is responsible for managing his or her own feelings in the face of the group's power and deciding what he or she will and won't share

5.40

Modulate Emotionality

- Keep emotionality at a level that enables the work of the group to continue
 - Example:
 - "We've been expressing some intense feelings here today....To prevent us from overload, it might be valuable to stop what we're doing and try together to understand what's been happening and where all these powerful feelings come from"

Source: Yalom, I. D. (1995). *The theory and practice of group psychotherapy*. 4th ed. New York: Basic Books. p. 350.

5.41

Group Size

- Number of members: Group therapy may be practised with more than two members and less than 15. Optimum number for group therapy is 8-12 members.

Source: Group Interventions. Ezhumalai, S et al. *Indian J of Psychiatry*- 2018 Feb, 60(Suppl 4): S51-51.

5.42

Small-Group Demonstrations: Instructions

- Decide:
 - In what phase of development is your group?
 - What portion of a group session will you demonstrate?
- Select a facilitator
- Select client roles from Resource Page 5.2
- Prepare an 8- to 10-minute group role-play
- Be creative!

5.43

Management of Issues in the Group

- Handling conflict in group (Resource Page 5.8)
 - Unhealthy interactions
 - Covert conflicts
 - Displaced anger
- Managing subgroups (Resource Page 5.9)
 - Make covert alliances overt
 - Reframe what the group is doing
 - Rearrange

5.44

Management of Issues in the Group (continued)

■ Responding to disruptive behavior (Resource Page 5.10)

- ▣ Talkative or interrupting clients
- ▣ Clients who flee a session
- ▣ Coming in late or absence
- ▣ Silence
- ▣ Tuning out
- ▣ Focusing only on others

5.45

Management of Issues in the Group-Instructions

- Read your assigned Resource Page
- Select a facilitator
- Select client roles from Resource Page 5.2
- Create a presentation *and* a demonstration role-play

5.46

Lunch

60 minutes

5.47

Small-Group Exercise: Issues in Group Management

Presentations

5.48

Group Therapy Participation Agreement

In order for group to work, a safe environment must be created and expectations for members and the leader must be understood by the participants. My experience with groups supports that the best way to create a safe environment for personal growth is for you to understand and to agree to these guidelines.

I. Confidentiality

Sharing in group can be anxiety-provoking, therefore I ask that you keep all information discussed in the group confidential. This request means that you may not discuss any information shared or the reactions of any member of this group with anyone outside of the group. You may talk about your own personal reactions, and are even encouraged to do that outside of group, but not about others' identifying information or reactions.

Only under the following conditions will I have to share information:

- a) If you sign a release of information for exchange of information with a third party.
- b) Therapists are required by law to report to the appropriate agency if there is suspicion of child or elder abuse.
- c) Therapists are required to intervene appropriately with the threats of serious harm to yourself or others. This could require reporting to police or another appropriate agency.
- d) The court of law subpoenas information for a legal proceeding.

II. Attendance

Group members are expected to make a commitment to attend group the entire 6 weeks, although I understand that making this commitment can be difficult. Members also agree to come on time every week. If you are running late or have an emergency/illness that prohibits you from coming to group, I ask that you call me at _____. If you know ahead of time that you will miss a later group session, I ask that you share the date of your absence with the group beforehand.

Group will always end on time, no matter what is being discussed. Coming back the next week will allow you to continue the discussion.

Members often feel anxious about participating in groups and seeing the results can take time. If you decide to leave before the group ends (before the 6 weeks are over) and have explored your concerns with me and other members, I ask that you come back to the

¹Reprinted with permission from the author, Susanne Stolcke, MFT.

group to say goodbye. Though perhaps hard to imagine now, members will begin to care about one another and will feel unresolved if you leave without any explanation.

I would also like to ask you to not drink alcohol or use any drugs before coming to the meetings.

III. Payment

The full payment of \$240 for the six 1 ½ hour group sessions is due before the first meeting. You may pay by check (made out to _____) or in cash.

Exercise—Potential Group Members: Client Profiles

1. **Male, age 18**, mandated into treatment by court. He is angry and upset that he was caught selling drugs and wants to be able to satisfy the court so he can get on with his life. He was going to start college but now his parents are withholding money until he straightens himself out. His father is recovering from an SUD and is also angry that he didn't see this coming. The father wants to participate in his son's recovery.
2. **Female, age 61**. She has four grown children and three grandchildren. The family lives in the same town and is described as very close. She has been battered for most of her marriage and stays at home to avoid having to deal with people. Her doctor prescribed tranquilizers for her nerves and a narcotic painkiller for the pain as a result of a recent broken arm. She has come to your organization only because her daughter has brought her, and her daughter is willing to come to treatment, too, to support her mother. The client says speaking in public is terrifying, and she would rather work individually with another woman.
3. **Male, age 23**, married, employed as a salesman. His new wife has said he has to go into treatment because she is pregnant and won't tolerate his daily pot smoking any longer. He is worried that his marriage is on the rocks and that his wife will leave with the baby. He has been using cannabis since age 14 and did some other drugs, too, before he met his wife.
4. **Female, age 45**, recently released from prison. She is HIV positive and has moved back in with her abusive boyfriend. Her three children are living with her sister. She has been using drugs since high school and is sick and tired of being down and out. She says she is angry all the time and knows that it will take a miracle for the system to let her live her own life.
5. **Male, age 28**, grew up in a violent household. He was beaten and psychologically abused throughout his childhood. He managed to escape at age 16 and lived on the streets for many years. He is worried about his HIV status. He has cut down on his use of heroin but has not been able to stop entirely. He has been unable to hold down a job for more than 8 months at a time. He heard about the trauma group and wants to join.
6. **Female, age 42**, single parent of three children, works part-time at the village school as an aide. Almost all of the men in her family have had serious alcohol problems. She is the first female in the family to be drinking heavily. Her sons won't speak to her because she is an embarrassment to them. She has lived in the village all of her life.

7. **Male, age 20**, is the son of immigrants from another country. He is the only one who speaks the local language in his family. The family moved to this country 10 years ago. He has always worked alongside his father and attended school. When they moved here, he was recruited into a gang and began using alcohol, cannabis, pills, and more recently heroin. He can't leave his gang and he can't get straight on his own either. He thinks the communication group will help him.
8. **Female, age 38**, married, with two children, works at the family laundry that is located in an area of serious economic decline. After a fire that nearly destroyed the business, she was prescribed tranquilizers to help her nerves and to sleep. She has been increasing her use of these drugs and has gone to multiple doctors to get more. One of her doctors heard that she was doing this and referred her for treatment. She is afraid to talk and is ashamed about what she thinks she has done to her family.
9. **Male, age 40**, married with three children. He has been using multiple substances off and on since age 16. His use has become much more frequent lately, and he is certain that his boss is going to fire him. He has been in two other treatment programs but was unable to stay more than 2 months at a time.
10. **Female, age 30**, single parent with four children. Her children, however, currently are living with their father. She has been hospitalized for depression twice during the past 10 years. She uses a bag of heroin every few days to feel okay. She loves her children, hates the system, and is worried that she will lose her children altogether.
11. **Male, age 55**, very involved in Narcotics Anonymous (NA). He has lost his family, job, and housing during the past 10 years because of his drug use. A friend recently got him into NA and the local church. He has been abstinent for 6 months with only two slips each lasting 1 day. He lives in a local sober home and wants to get his life back together.
12. **Male, age 60**, is married with two grown children and owns a local shop. Since a traumatic incident 6 months ago where he was beaten severely during a hold-up, he has been taking opioid pain killers to the point that he cannot go to work or function. Before the hold-up he did not use drugs and drank only occasionally. His family is embarrassed and afraid that he will lose the shop and their main income.

Exercise—Types of Groups

Adult Early Recovery Group

This group meets twice a week and is focused on helping people achieve abstinence and become actively engaged in a therapeutic and social recovery process.

Communication Group

This group meets weekly. The goal is to improve verbal and non-verbal communication using a combination of skill development and interpersonal process. Individuals, couples, and other family members are invited to participate.

Relapse Prevention Group

This group meets twice weekly. It uses a course of topics along with open group discussion. Members are expected to have experienced a period of abstinence and now need additional information, support, and strategies to extend the length of abstinence.

Trauma Group

This is a support and interpersonal process group for people who have experienced trauma. The purpose of the group is to provide a safe place to examine feelings and learn ways to effectively cope, as well as an opportunity for members to give support to and receive support from other people who have experienced trauma. Most current members are women.

Anger Management Group

This is a skill-development and cognitive-behavioral therapy group to teach participants how to recognize and manage their anger, as well as understand the effect their anger has on other people. Most current members are men.

No Group

Use this for anyone you deem inappropriate for a group at this time.

Resource Page 5.4: Types of Groups: Membership, Timeline, and Focus

Membership/ Time-Limited or Ongoing	Time-Limited	Ongoing
Static Membership	Characteristics ■ New members admitted only in earliest stages of group development ■ Groups begin and end with same membership ■ Learning built on what has happened in prior meetings Examples ■ Short-term counseling groups—process ■ Skills-building and psychoeducational groups—content ■ Relapse prevention groups—process	Characteristics ■ Group size fixed ■ New members enter only after vacancy or graduation ■ Members expected to stay for a substantial period ■ Dynamics of group process (such as individuals' boundaries and the roles different members assume) are the primary source of learning and healing for participants Examples ■ Ongoing interpersonal groups—process ■ Long-term supportive counseling groups—process

Revolving Membership	Characteristics ■ Number of sessions usually fixed ■ Learning at each session relatively independent of previous group sessions Examples ■ Psychoeducational groups—content ■ Expressive counseling groups (dance therapy, psychodrama)—process ■ Some skills-building groups—content	Characteristics ■ Clients may: 1. Stay as long as they wish; 2. Be required to attend sessions with certain topics; or 3. Be required to attend for a set number of weeks. ■ Usually a set maximum number of participants ■ Active counselor leadership Examples ■ Day hospital check-in groups—process ■ Continuing care drop-in groups—process ■ Transition groups for clients leaving inpatient and moving to outpatient care—process ■ Psychoeducational groups—content ■ Expressive counseling groups—process ■ Long-term supportive groups, such as ongoing continuing care groups and maintenance groups—process
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Adapted from source: Center for Substance Abuse Treatment, (CSAT) (2005). *Substance abuse treatment: Group therapy*. Treatment Improvement Protocol (TIP) Series 41. HHS Publication No. (SMA) 05-3991. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA).

Resource Page 5.5: Phases of Group Work: Beginning Phase—Preparing the Group To Begin¹

During the beginning phase of group counseling, issues arise around topics such as orientation, beginners' anxiety, and the role of the leader. The purpose of the group is outlined, working conditions of the group are established, members are introduced, a positive tone is set for the group, and group work begins.

This phase may last from 10 minutes to a number of sessions. In a revolving-membership group, this process will happen each time a new member joins the group.

The primary tasks in the early phase of group development are:

- Introductions;
- Establishing and/or reviewing a group agreement;
- Providing a safe, cohesive environment;
- Establishing norms; and
- Facilitating the work of the group.

Introductions

Even in short-term revolving membership groups, it is important for the leader to connect with each member. This connecting can be as simple as a friendly smile and a one-word welcome.

At this time all members should have an opportunity to give their names and say something about themselves. Some leaders ask members to introduce themselves. Others let the group figure out how to get acquainted.

One cautionary note, however, is that many clients treated for substance use disorders (SUDs) also have histories of emotional and physical abuse. Merely having attention directed toward these individuals can trigger feelings of shame. So, although it is extremely important to make connections between and among group members and to involve them in the process, the sensitive leader will not insist on lengthy participation from new members. Emotional safety always should be foremost in the group leader's mind.

At the first meeting of a fixed membership group, group members also may be asked whether they know anyone else in the group. If there are connections that might cause difficulties, they will be discovered at the start.

¹Excerpted from source: CSAT. (2005). *Substance abuse treatment: Group therapy*. Treatment Improvement Protocol (TIP) Series 41. HHS Publication No. (SMA) 05-3991. Rockville, MD: SAMHSA.

Each new member who joins the group is entering the beginning phase of the group—for that individual. It is not easy to find one's place in an already-established group. The leader can help build bridges between old and new members by pointing out that it is difficult to be the new member and by encouraging old members to help the new one join the group.

Group agreement review

The group agreement should be reviewed in an interactive way, involving the group members in discussion of the terms. The group leader should ask members whether they are aware of concerns that might require additional group agreement provisions to make the group a safe place to share and grow. Group members should have an opportunity to suggest and discuss further guidelines. In addition, the group agreement should be reviewed periodically.

Providing a safe, cohesive environment

During the beginning phase of the group, all members should feel that they have a part to play in the group and have something in common with other members. This cohesion, or unity, both among clients and between the clients and the group leader, will affect the productivity of work throughout the therapeutic process.

In the beginning phase, the leader usually needs to be more supportive and active than will be necessary once the group gets underway. If particular members have spoken very little, it helps to let them know that their contributions are welcome. The leader might say something like, "We haven't heard much from you tonight, Otieno, but perhaps next week the group will have a chance to get to know you a little bit more."

To help group members bond with one another, the leader should encourage the connections members begin to make on their own and should point out similarities among them. The leader might say, for instance, "It seems that Alice and Njoki, and perhaps others in here as well, are struggling with very similar problems with their anger."

The leader also is responsible for ensuring that early in the group, emotional expression stays at a manageable level. Otherwise, members quickly may feel emotionally overloaded and begin to withdraw. Care always should be taken not to shame group members or to allow others in the group to engage in shaming behaviors.

The leader also should bear in mind that in the beginning phase, the group is unable to withstand much conflict. Before the group develops trust and cohesion, conflict is likely to disrupt proceedings or even to threaten a group's existence, so it is unwise to permit confrontation. Instead the group leader should encourage interaction that minimizes aggression and hostility.

Establishing norms

It is up to the leader to make sure that healthy group norms are established and that counterproductive norms are precluded, ignored, or extinguished. The leader shapes norms not only through responses to events in the group, but also by modeling the behavior expected of others.

Healthy norms to be encouraged in a process group include honesty, spontaneity, a high level of attentive involvement, appropriate self-disclosure, the desire for insight into one's own behavior, nonjudgmental acceptance of others, and the determination to change unhealthy behavior.

Unhealthy norms that could hamper a process group include a tendency to become leader centered, one-dimensional (that is, all-loving or all-attacking), or so tightly knit that the group is hostile to new members. The leader should respond quickly and clearly to habits that impede group work and that threaten to become normative.

Facilitating the work of the group

The leader *facilitates* the work of the group, whether by providing information in a psychoeducational group or by encouraging honest exchanges among members in other types of groups.

Most leaders try to keep the focus on the here and now as much as possible.

The leader also may need to prompt a new group with questions such as, "You seem to be responding to what James was sharing. Can you tell us something about what was going on for you as he was talking?"

Resource Page 5.6: Phases of Group Work: Middle Phase—Working Toward Productive Change¹

The group in its middle phase encounters and accomplishes most of the actual work of therapy. During this phase, the leader balances content, which is the information and feelings overtly expressed in the group, and process, which is how members interact in the group. The therapy is in both the content *and* the process. Both contribute to the connections between and among group members, and it is those connections that are therapeutic.

Many new leaders focus strongly on content, but thoughtful attention to group process is extremely important. Even in an educational group, tension in the room, rolling eyes, or side conversations can interfere with messages that need attention. In a process group, these cues are part of the work and need to be explored actively, but even in more content-oriented groups, non-verbal cues should not be ignored.

The group, then, is a forum where clients interact with others. In this give and take of therapy, clients receive feedback that helps them rethink their behaviors and move toward productive changes. The leader helps group members by allocating time to address the issues that arise, by paying attention to relations among group members, and by modeling a healthy interactional style that combines honesty with compassion.

Middle phase issues and tasks for the facilitator in this phase include:

- Keeping the group focused and in the “here and now”;
- Modeling a healthy interactional style; and
- Facilitating rather than running or directing the group.

Keeping the group focused and in the here and now

Counselors can help group members stay on track and deal with the here and now. Examples of the type of interventions that can be helpful to keep the group focused:

- When members talk about things from outside the group: “How does talking about what happened (over there) make you feel in this group?”
- When members are quieter than usual: “How does the silence in the room make you feel?”

¹Excerpted from source: CSAT. (2005). *Substance abuse treatment: Group therapy*. Treatment Improvement Protocol (TIP) Series 41. HHS Publication No. (SMA) 05-3991. Rockville, MD: SAMHSA.

Modeling a healthy interactional style

It is especially helpful to have two counselors in the group doing co-counseling. The co-counselors can model effective communication, as well as modeling how to resolve conflicts in an appropriate way. In coed groups, having a counselor of each gender helps model appropriate and respectful male–female relationships, too. Even in situations where there is only one group counselor, the counselor has the responsibility to treat all the clients with respect and model healthy communication and other interactions with them.

When the group is working, the counselor role is to guide interactions so that group members stay engaged. When the group is not working, the counselor role is to make the covert overt and the implicit explicit. Often, simply stating what has happened and asking how it makes group members feel is enough.

Resource Page 5.7: Phases of Group Work: End Phase—Reaching Closure¹

Termination is a particularly important opportunity for members to honor the work they have done, to grieve the loss of associations and friendships, and to look forward to a positive future.

The group begins this work of termination when the group as a whole reaches its agreed-on termination point or a member determines that it is time to leave the group. In either case, termination is a time for:

- Putting closure on the experience;
- Examining the impact of the group on each person;
- Acknowledging the feelings triggered by departure;
- Giving and receiving feedback about the group experience and each member's role in it;
- Completing any unfinished business; and
- Exploring ways to carry on the learning the group has offered

Departing clients can be classified into three groups:

- *Completers* have finished the work they came into group to do.
- *Plateauers* are not really finished, but their progress has slowed or stopped for the time being.
- *Fleers* feel an irresistible need to escape as rapidly as possible, often because they have encountered an upsetting reality in the group or in their lives outside the group.

Completing a group successfully can be an important event for a group member. It may be the first time in a long while that he or she has finished something successfully. Terminating with the group also is an opportunity for clients to practice parting, with the understanding that a departure leads to the next opportunity for connection.

Even positive, celebrated departures, however, can raise strong feelings, so soon-to-depart members of an ongoing group should give ample advance notice (perhaps 4 weeks) to give the group time to process the feelings associated with the leave-taking. In general, the longer members have been with the group, the longer they may need to spend on termination. The group facilitator plays an important role in termination, either facilitating an individual's good-bye to the group or the group's good-bye to itself (if the group is ending).

¹Excerpted from source: CSAT. (2005). *Substance abuse treatment: Group therapy*. Treatment Improvement Protocol (TIP) Series 41. HHS Publication No. (SMA) 05-3991. Rockville, MD: SAMHSA.

Some clients may be reluctant to part from the group and the facilitator. Some clients who are exquisitely sensitive to abandonment, for example, may deny the gains they have made. They need reassurance that, once they improve, they no longer will need the therapist. In other reluctant clients, symptoms may recur. These people need help seeing the apparent setback for what it really is: fear of termination

The group may be invited to explore the proposal that a member leave the group. In addition, the leader might ask clients about to terminate to classify themselves as completers, plateauers, or fleers. If the client is a fleer, that person might be asked a hypothetical question: If you remained in group, what do you think you might work on? Such a query might bring to light the issue the fleer wants very much to avoid.

Whatever attempts are made to dissuade premature termination, some people with SUDs inevitably will leave groups abruptly, for a variety of reasons. Groups should be forewarned that sudden changes may take place, and leaders should be prepared to help group members cope with these changes.

Groups (and counselors!) may subtly pressure a particular group member to remain because they value the departing member's contributions and will miss him or her. Group members need reassurance that when a senior member leaves, someone else will assume the role just vacated.

Resource Page 5.8: Issues in Group Management—Handling Conflict

Handling conflict in group is an issue that all counselors will have to deal with. Conflict in group is normal, healthy, unavoidable, and a learning opportunity for participants. The counselor needs to be highly aware of the verbal and non-verbal reactions of group members to ensure they can manage the emotional level of any conflict.

Conflict in group often falls into one of three general categories:

- Unhealthy interactions;
- Covert conflicts; or
- Displaced anger.

Unhealthy interactions

A counselor often can facilitate interactions between members in direct conflict by simply calling attention to the interaction by asking the group something like: “Hold on a minute. What seems to be going on in the group right now?”

A counselor can help group members work through conflict by helping them focus on their *feelings* rather than the *content* of a conflict. This can help everyone get to the root of conflict rather than getting lost in the content.

A counselor can also call attention to more subtle patterns of conflict in the group.

For example, a group may have a member, Mary, who frequently disagrees with others. Group members regard Mary as a source of conflict, and some of them may even ask Mary (the scapegoat) to leave so that they can get on with group work.

In such a situation, the counselor might ask, “Do you think this group would learn more about handling this type of situation if Mary *left* the group or *stayed* in the group?” The counselor could also ask the group what the distraction of the situation might be helping the group to avoid discussing.

Bickering between members can often be quickly stopped by:

- Directing members’ attention to the objectives of the session;
- Mentioning the time limits of the session;
- Asking the members to shelve the issue for the moment; or
- Summarizing the disagreement by emphasizing points of agreement and minimizing points of disagreement.

Covert Conflicts

A covert conflict is one that is “underground” or not openly shown for what it is. A counselor can help a group label covert conflicts and bring them into the open. The observation that a conflict exists and that the group needs to pay attention to it actually makes group members feel safer.

The counselor is not responsible, however, for resolving conflicts. Once the conflict is observed, the decision to explore it further is made based on whether such inquiry would be productive for the group as a whole. In reaching this decision, the counselor should consider the function the conflict is serving for the group. It actually may be the most useful current opportunity for growth in the group.

Displaced anger

Group leaders also should be aware that many conflicts that appear to scapegoat a group member are actually displaced anger that a member feels toward the counselor. When the counselor suspects this kind of situation, the possibility should be directly presented to the group with a comment such as, “I notice, Willy, that you have been upset with Amina quite a bit lately. I also know that you have been a little annoyed with me since a couple of weeks ago about the way I handled that phone call from your boss. Do you think some of your anger belongs with me?”

Resource Page 5.9: Issues in Group Management—Managing Subgroups

Subgroups inevitably will form in groups that counselors lead. Counselors can sometimes identify in advance whether there are automatic subgroups that will form, such as when clients have previously been in treatment together or when there are clients who work together.

Like conflict, subgroups are not always negative. For example, a group facilitator may intentionally foster a subgroup that helps marginally connected clients move into the life of the group. This might involve a question like, “Nancy, do you think it might help Linah if you talked some about your experience with this issue?”

Furthermore, to build helpful connections between group members, a group member might be asked, “Bob, who else in this group do you think might know something about what you’ve just said?”

When subgroups are negative, counselors can manage them in the following ways.

Make covert alliances overt. *Covert* means an alliance is underground or not openly shown for what it is. The counselor can involve the group in identifying subgroups by saying something like, “I notice Moses and John are finding they have a good deal in common. Who else is in their subgroup?”

Reframe what the subgroup is doing. For example, a counselor can say to subgroup members, “What are you helping the group avoid talking about by talking among yourselves?”

Rearrange. At other times, a change in the room arrangement may be enough to change undesirable combinations or alliances.

Resource Page 5.10: Issues in Group Management—Managing Disruptive Behavior

Managing and responding to disruptive behavior is a problem all counselors will have to deal with in groups. There are some common types of disruptive behavior counselors often need to manage:

- Clients who do not stop talking or who interrupt;
- Clients who flee a session;
- Clients who are tardy or miss sessions;
- Clients who are silent;
- Clients who tune out during sessions; and
- Clients who participate, but only about issues pertaining to others.

Clients who cannot stop talking or who interrupt

Overtalkers. When a client talks on and on, he or she may be nervous or just naturally wordy. The facilitator can simply move the group on by:

- Interrupting (when the person takes a breath!) with “That’s an interesting point; let’s see what everyone else thinks” or thanking the person and restating relevant points; and
- Suggesting, “Let’s put others to work.”

The person also may not know what is expected in a group. The group leader might ask this client, “What are you hoping the group will learn from what you have been sharing?” If the client’s answer is, “Huh, well nothing really,” it might be time to ask more experienced group members to give the client a sense of how the group works.

The facilitator can also explore whether the group is allowing this overtalking to avoid other issues.

Interrupters. Interruptions disrupt the flow of discussion in the group, with frustrating results.

The client who interrupts is often someone new to the group and not yet accustomed to its norms and rhythms. The leader may invite the group to comment by saying, “What just happened?” The facilitator can also let the interrupter know that he or she will have adequate chance to share later on. The facilitator needs to keep this promise.

Clients who flee a session

Clients who run out of a session often are acting on an impulse that others in the group share. It would be helpful to discuss these feelings with the group and to determine what members can do to talk about these feelings when they arise.

The leader should stress the point that no matter what is going on in the group, the work requires members to remain in the room and talk about problems instead of attempting to escape them. If a member is unable to meet this requirement, reevaluation of that person's placement in the group is indicated. Note that although groups debate many issues, the decision to remove an individual is not one the group makes. On the contrary, the leader makes the decision and explains to the group in a clear and forthright manner why the action was taken.

Coming late or missing sessions

Sometimes, counselors view the client who comes to group late as a person who, in some sense, is behaving badly. It is more productive to see this kind of boundary violation as a message to be clarified. Ask the client or the group members whether they have ideas why a person is late or has missed a session.

Silence

A group member who is silent is conveying a message as clearly as one who speaks. Silent messages should be heard and understood, because non-responsiveness may provide clues to clients' difficulties in connecting with their own inner lives or with others. Silence also can be an indicator of covert anger that needs to be addressed.

Silent clients may be gently prompted: "Alice, you're very quiet today. I'm thinking you might be able to relate to what Nancy was just saying."

If clients continue to be silent in group, it is worth re-thinking whether they may have been placed inappropriately.

Special consideration also is sometimes necessary for clients who speak the group's primary language as a second language. Such clients may be silent, or respond only after a delay, because they need time to translate what has just been said into their first language. Experiences involving strong feelings can be especially hard to translate, so the delay can be longer.

Tuning out

When the group is in progress and clients seem present in body but not in mind, it helps to tune into them just as they are tuning out. The leader should explore what was happening when an individual became inattentive. Perhaps the person was escaping from specific difficult material or was having more general difficulties connecting with other people.

It may be helpful to involve the group in giving feedback to clients whose attention falters. It also is possible, however, that the group as a whole is sidestepping matters that have to do with connectedness. The member who tunes out might be carrying this message for the group.

Participating only about the issues of others

Even when group members are disclosing little about themselves, they may be gaining a great deal from the group experience, remaining engaged around issues that others bring up. The facilitator may want to wait a while and see whether the client eventually begins talking more about his or her own issues.

The facilitator also may invite the client to express something personal: “I noticed you nodding your head while Daniel was speaking. What is it that you were relating to?”

Module 5—Group Counseling: Basic Skills, Summary

Introduction

Group counseling is *not* the same thing as doing individual counseling in a group setting. Counselors may believe they are providing group counseling, but may be only using their individual counseling skills. The needs of the group as a whole must be balanced with the needs of individuals in the group. Group counseling includes good facilitation skills that enable the group to do most of the work.

Preparing clients for groups—Overview

- There has been a good deal of research that has looked at the value of preparing clients for groups. Most writers agree that preparing clients helps groups become more therapeutic more quickly and also seems to have a positive effect on client improvement
- Be aware that not all types of clients are right for all types of groups. For example
 - Clients with a co-occurring mental disorder, such as a severe depressive or social anxiety disorder, may not be able to function well in a group setting.
 - Clients with a co-occurring personality disorder may need a group with very strict boundaries to avoid a negative group experience or to avoid negatively affecting other group members.
 - Each client must be assessed for his or her own individual needs in treatment.
- The counselor should recognize and affirm clients' expectations about group counseling by:
 - Asking about expectations;
 - Correcting any misconceptions;
 - Affirm positive expectations; and
 - Addressing and reframing any fears.
- For example, a client may fear he or she is "different" from other group members, which may be true. The counselor can explore issues of difference (sexual orientation, ethnicity, tribe or clan, for example) and reframe the perceived "problem" by stressing the benefit of having unique perspectives in the group.
- Whatever type of preparation for group is used, these are the goals of preparation:
 - Establish a preliminary alliance between client and counselor;
 - Gain a clear mutual understanding about the client's expectations; and
 - Offer information and instruction about the group.

- To deal with initial client anxiety about joining a group; and
 - To present and gain acceptance of a group agreement.
- Written group agreements also can help prepare clients for group work by clarifying just what is expected of them. This can become part of their orientation to the group and be given to them in a handout. Group agreements typically include specifics about:
- Attendance. For example, being on time and attending a minimum number of sessions.
 - Confidentiality. For example, “what’s said in the group stays in the group.”
 - Physical contact. For example, whether hugging or other touch is okay with permission and expectations regarding avoidance of negative touch, like poking, pushing, or hitting.
 - Use of substances. For example, a client’s not being admitted to group if he or she is under the influence of a substance.
 - Participation. For example, an expectation of at least minimal sharing in each group session.
 - Time expectations. For example, the counselor’s punctuality; starting and ending on time.
- Clients who have experienced trauma, especially sexual abuse, may need a homogeneous group (meaning a women-only or men-only group, or a group with others who have had similar experiences).
- Clients in the throes of a life crisis may require more concentrated attention than groups can provide.
- Finally, clients who choose not to participate in group therapy should not be criticized or penalized, even if it means you need to refer them to another program for services. Effective treatment programs that focus on individual needs do not require all clients to attend group. Clients’ individual needs must take precedence.
- Preparing clients for group work can take as little as one session to as long as several weeks.
- In an individual session or sessions, Select the persons according to their appropriateness; For example, first screen clients for appropriateness:
- Assess their ability to function in group;
 - Assess their stage of change; and
 - Assess their willingness and motivation to participate.
- This assessment not only helps the counselor place the client in an appropriate group, but it also helps the counselor know what to expect.

- The counselor also should provide information about the group. For example:
 - How group counseling compares with another group experiences the client may have had.
 - The benefits of group counseling, or how group might specifically help the client;
 - How the group is structured; for example, is it ongoing or time-limited?; and
 - The kinds of issues the group addresses.
- The counselor can also tell the client that people sometimes want to quit group prematurely, so the client is not surprised if those feelings surface.
- Pre-group meetings are very helpful to:
 - Clarify expectations (of both the client and the treatment program);
 - Set up basic ground rules;
 - Explore the advantages of group therapy; and
 - Correct any misconceptions about groups.
- An important part of an individual's success in group therapy depends on being integrated into the appropriate group. Before placing a person in a particular group, the following should be considered:
 - The client's characteristics, needs, preferences, stage of change, and stage of recovery;
 - The program's resources; and
 - The nature of the group or groups available in your setting.

General types of groups: Membership, timeline, and focus

- There are two ways group membership is handled: static membership or revolving membership:
 - Static membership groups keep the same membership throughout the life of the group with no new people joining.
 - Revolving membership groups have people come and go, join and leave, and the group continues on despite the changing membership.
- In terms of the timeline, we can look at time-limited versus ongoing groups. Time-limited groups have a set number of sessions. For example, an education group may have 10 or 15 sessions with specific topics to cover in each session. Ongoing groups have no specific end date.

Timeline

- Both time-limited and ongoing groups can have either static or revolving membership, depending on the focus of the group; however, ongoing groups are more likely to have revolving membership.

Focus

- The focus of a group can be content-oriented or process-oriented, although the Content-oriented groups focus on identified topics for each session, but it is still important to pay attention to the group dynamics and how members interact with one another and the counselors. Examples of content-oriented groups are education or skills-training groups.
- Process-oriented groups focus on the interaction between group members and counselors and are “here and now” focused. What is said in the group comes out of the group’s needs—there is no specific topic identified for each session.
- Some groups also might have a split focus. For example, a group for clients with HIV/AIDS might be content-focused in that it emphasizes issues specific to living with the virus, but also process-oriented in that no specific topic may be identified for a particular session and clients also are invited to share their feelings.

Phases of Group Development

- There are three typical phases of group development:

1. Beginning phase;
2. Middle phase; and
3. End phase.

1. Beginning phase

- During the beginning phase of group counseling, issues arise around topics such as orientation, beginners’ anxiety, and the role of the leader. The purpose of the group is outlined, working conditions of the group are established, members are introduced, a positive tone is set for the group, and group work begins.
- This phase may last from 10 minutes to a number of sessions. In a revolving-membership group, this process will happen each time a new member joins the group. Try to enlist the assistance of the group in introducing new members to the process, group rules and goals. This helps create a connection between the existing members and the new ones.
 - The primary tasks in the early phase of group development are:
 - Introducing members and facilitators;
 - Establishing and/or reviewing a group agreement;

- Providing a safe, cohesive environment;
- Establishing norms; and
- Initiating the work of the group.

2. Middle phase;

- The group in its middle phase encounters and accomplishes most of the actual work of therapy. During this phase, the group leader balances content, which is the information and feelings overtly expressed in the group, and process, which is how members interact in the group. The therapy is in both the content and process. Both contribute to the connections among group members, and it is those connections that are therapeutic.
- The middle phase of group is typically the longest phase in a group's life. Middle phase issues and tasks for the group leader in this phase include:
 - Balancing content and process
 - Noticing and rolling with resistance, one of our core skills;
 - Keeping the group focused and in the "here and now";
 - Modeling a healthy interactional style; and
 - Facilitating rather than running or directing the group. We'll talk about this more in a few minutes.

3. End phase.

- The end phase of a group, or termination, is a particularly important opportunity for members to honor the work they have done, to grieve the loss of associations and friendships, and to look forward to a positive future. As with the beginning phase, even an ongoing group will go through a termination phase as each participant leaves.
- End phase issues and tasks include:
 - Putting closure on the experience;
 - Examining the impact of the group on each person;
 - Acknowledging the feelings triggered by departure;
 - Giving and receiving feedback about the group experience and each member's role in it;
 - Completing any unfinished business; and
 - Exploring ways to carry on the learning begun in the group.
- More information about the phases of group development is in Resource Pages 5.5, 5.6, and 5.7

Structuring a Group Session

- One way to be intentional in group counseling is to think carefully about what you would like the group to accomplish during a given session. Another way to be intentional is to ensure that each session has a certain structure.
- By having a structure, the group leader can ensure that important aspects of the work are protected, and the group members know what to expect from a session. This is a group that “starts well and ends well” by using beginning and ending rituals.
- A common group session structure is:
 1. Opening and welcome;
 2. Verification;
 3. Review group norms and rules;
 4. Active work;
 5. Summary and homework; and
 6. Closing.

1. **Opening and Welcome**

- The welcome and opening portion of a session includes greeting each participant warmly and starting the session ON TIME. A simple “Let’s begin” will do. Beginning a session on time sends the message that the work of the group is important. A group leader who is consistently late for group meetings sends the message that the group is not important. It also conveys a lack of respect for participants’ time.
- Waiting for late group members reinforces lateness and again conveys lack of respect for group boundaries and those participants who made the effort to arrive on time.
- The welcome and opening is a time to introduce any new members to the group.
- There may be announcements to be made and information to be provided, such as whether any group members will be late or absent or whether the leader plans to be absent in the near future.
- Some groups also have an opening ritual.

2. **Verification;**

- The verification portion of the session can serve a number of purposes, depending on the type of group. In a psychoeducational group, for example, the group leader might ask participants what they remember from the last session or whether they used anything they learned.
- In any type of group, it also might be a time to follow up on any homework assignments participants had.

- In a process-oriented group, it might simply mean asking participants, “How are you all feeling today?”
- The group leader needs to be careful not to allow the Verification take on a life of its own.

3. Review group norms and rules

- This portion of the session involves reviewing group norms and rules that have already set and agreed among the members. It also provides the opportunity for the way-forward.

4. Active work;

- The active work portion is the heart of the group. The work can be either content-oriented or process-oriented, depending on the purpose of the group. It also may vary depending on the phase of group development, as we discussed.

5. Summary and homework

- The summary and homework portion is just what it sounds like. The group leader summarizes the work of the group or asks the group to summarize its work. Any homework assignments given during the session are reinforced, or new homework is assigned.
- The leader also should always affirm the work of the group, as specifically as possible and ask group members who should be affirmed. For example: “You did a great job today supporting Matthew” or “This was a very emotional session; you were all really brave and hung in there” or “Is there anyone else you would like to compliment for what they did in group today?”
- Sometimes the summary portion needs to include another check-in. If a session was particularly difficult for a participant, for example, the leader should check in with the person to be sure that he or she is OK and has some closure. A check-in with the whole group may be in order, too, if a session was difficult. The leader needs to be sure that no one is in need of follow up work to be emotionally safe.

6. Closing

- As with openings, group sessions often close with some type of ritual. One example is to end by asking participants what was learned that they are taking away from the group.
- Clearly, the group leader is responsible for creating a structure that protects and enhances the work of the group. However, the leader’s responsibility also involves knowing when to back off and allow the group to function as a group.

Avoiding a leader-centered process group

- In a content-oriented group, such as a psychoeducational group, a leader usually takes charge and teaches content. In a content-oriented group, it is entirely appropriate that the group is mostly leader-centered.
- In a process group, however, the leader's role and responsibilities should shift dramatically from content to process. A process group that remains leader-centered limits the potential for learning and growth yet, all too often, the leader remains at the center of the group.
- For example, a common sight in a leader-centered group is a series of one-on-one interactions between the leader and individual group members. These one-on-one interventions do not use the full power of the group to support experiential change or to build authentic, supportive interpersonal relationships.
- One way of looking at the appropriate role of the leader of a process group is to see the role as facilitation rather than leadership. Facilitation is the practice of supporting a group's process rather than creating or directing it.
- There are a lot of ways group facilitators can keep the focus on the group and group process. For example, good facilitators avoid doing for the group what it can do for itself:
- A question to the facilitator can be turned back over to the group: "That's an interesting question; how would the rest of you answer that?"
- Asking a group member to direct a comment to another group member. For example:
 - **Client:** What Linah just said really annoys me.
 - **Counselor:** Can you look at Linah and tell her more about what you're feeling?
- Not always being the one to break a silence; waiting can communicate respect for the group's ability to move itself forward. Silence can be very productive, so don't be impatient. You can eventually call on another group member to say something. One way to do this is to remind participants that it is their group.
- Asking the group to comment on process. For example, "It feels tense in here today. What do you think is going on with the group?"
- Good facilitators also teach group members the skills necessary to support and encourage one another because too much or too frequent support from the facilitator can lead to approval-seeking, which blocks growth and independence.
- Supporting one another, of course, is a skill that will develop over time throughout the phases of group development (we'll be talking more about phases of group development in just a few minutes). For example, the facilitator can:

- Model communicating support in the early stages of a group. This includes appropriate eye contact, posture, non-verbal attentive listening, and other behavior you want the group members to exhibit;
- Teach specific skills in content-oriented groups;
- Reinforce and affirm participants whenever they communicate support in the middle stages of group development; for example: “What’s it like, Wilson, to communicate your thoughts so clearly to Linah and to have her understand you so well?” or “What was it like to be able to communicate your frustration so directly?”; and
- Not rush in to offer support to a participant in the later stages of group, but allow the group to do so. If necessary, a facilitator can simply prompt the group. For example: “Joseph, my guess is at least six other people here are experts on this type of feeling. What does this bring up for others here?”

Emotional Contagion

- Of course, the group facilitator is ultimately responsible for keeping the group functioning and safe. Facilitator interventions can help both individuals and the group move forward.
- The group facilitator also needs to step up whenever there is a threat to group functioning and safety. The threat may come in the form of disruptive behavior from a group member; we’ll talk more about that later. Another threat is that of emotional contagion.
- For example, another’s sharing, such as an agonized account of sexual abuse, can stir frightening memories and intense emotions in listeners. In this powerful and emotional atmosphere, the spreading excitement of the moment, or emotional contagion, can overwhelm group members and the group process.
- To prevent or counter emotional contagion, the facilitator needs to:
 - a. Protect individuals;
 - b. Protect boundaries; and
 - c. Regulate emotionality.
- If someone is sharing intense emotions, the counselor can affirm the courage it takes to share. This can also help contain emotion.

1. **Protect individuals;**

- To protect individuals, the facilitator should guard the right of each member not to be involved in emotional discussions. To do this, the facilitator can make it clear that each group member has a right to private emotions and feelings.

- When the group pressures a member to disclose information, the leader should remind the group that members need reveal information about themselves only at levels with which they are comfortable.

2. *Protect boundaries*

- Similarly, to protect boundaries the facilitator needs to make it clear that each client is responsible for managing his or her feelings in the face of the group's power and deciding what he or she will and won't share.

3. *Regulate emotionality*

- At all times, the facilitator should be mindful of the need to modulate emotionality always keeping it at a level that enables the work of the group to continue.
- Irvin Yalom, an expert on group dynamics, suggests an intervention that group facilitators could use to limit conflict or almost any unacceptable escalation of emotion:
 - "We've been expressing some intense feelings here today.... To prevent us from overload, it might be valuable to stop what we're doing and try together to understand what's been happening and where all these powerful feelings come from."

Group Size

- An ideal number of participants for group therapy can range from more than two members and less than 15 members. However, an optimal number for a group is 8-12 members.

Issues in Group Management

- Information on issues in group management is found in Resource Pages 5.8–5.10.

¹¹Yalom, I. D. (1995). *The theory and practice of group psychotherapy*. 4th ed. New York: Basic Books. (p. 350).

MODULE 6

PSYCHOEDUCATION GROUPS FOR CLIENTS AND FAMILIES

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Content and Timeline	
Activity	Time
Introduction to Module 6	10 minutes
Large-group exercise: Value of psychoeducation	10 minutes
Presentation: Types of psychoeducation groups	10 minutes
Presentation: Leadership	15 minutes
Break	15 minutes
Presentation: Psychoeducation content	5 minutes
Small-group exercise: Psychoeducation content	20 minutes
Presentation: Psychoeducation and stages of treatment	5 minutes
Small-group exercise: Psychoeducation and stages of treatment	30 minutes
Day 4 wrap-up	10 minutes
End of day 4	
Day 5 welcome and overview	5 minutes
Presentation: Family psychoeducation	5 minutes
Large-group discussion: What are your programs doing?	10 minutes

Module 6 Goals and Objectives

Training goals

- Provide a basic understanding of psychoeducation and its purpose;
- Provide an overview of the types of information typically covered in a psychoeducation group; and
- Provide an understanding of how to provide psychoeducation to people who are newly recovering.

Learning objectives

Participants who complete Module 6 will be able to:

- Define and describe “psychoeducation” and differentiate it from group therapy;
- Develop topics for both a skills-based group and an information-based group;
- Develop content for a psychoeducation group; and
- Assess their programs’ psychoeducation services and identify possible improvements.



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Basic Counseling Skills
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MODULE 6—PSYCHOEDUCATION GROUPS FOR CLIENTS AND FAMILIES



DAP
Drug Advisory Programme

Learning Objectives

- Define and describe “psychoeducation” and differentiate it from group therapy
- Develop topics for both a skills-based group and an information-based group
- Develop content for a psychoeducation group
- Assess your program’s psychoeducation services and identify possible improvements

6.2

Psychoeducation

- What is psychoeducation?

6.3

Definition of Psychoeducation

Psychoeducational groups educate clients and families about substance abuse and related behaviors and consequences. This type of group presents structured and specific content, often taught using videos, CDs or lectures. Frequently, an experienced group leader will facilitate discussions of the material

Source: Center for Substance Abuse Treatment. (2005). *Substance abuse treatment: Group therapy*. Treatment Improvement Protocol (TIP) Series 41. HHS Publication No. (SMA) 05-3991. Rockville, MD: Substance Abuse and Mental Health Services Administration.

6.4

Psychoeducation and Group Therapy: Similarities

- Group of clients with similar characteristics
- Common goal
- Focus on the effects of substance use and recovery
- Facilitated by a trained and experienced leader
- Encourages interaction among clients

6.5

Differences

- Focus on education, not therapy
- Emphasis on information, not feelings
- Emphasis on skill building, not behavioral change



6.6

Large-group Exercise: Value of Psychoeducation

- Why should we offer psychoeducation to our clients?
- How can it benefit them?
- What are possible outcomes for clients and family members?

6.7

Types of Groups

- Clients only
- Family only
- Family and clients

6.8

Skills-based Groups

- Teach *how*, not *what*
- Examples of skills:
 - ▣ Problem-solving
 - ▣ Techniques for managing cravings
 - ▣ Refusing drug offers
 - ▣ Other relapse-prevention strategies
 - ▣ Emotion regulation techniques

6.9

Psychoeducation groups: For Clients or Families

- Address knowledge, not skills
- More didactic than skills-based
- More specific
- Less interaction in group
- No discussion of personal issues

6.10

Group Leader: Qualifications

- Investment in providing psychoeducation
- Demonstrated concern for clients
- Experience in leading educational groups
- Familiarity with agency's treatment programs
- Experience with clients and families
- Trained professional, with experience and skills in group management and addiction



6.11

The Group Leader: General Tasks

- Help identify appropriate group members
- Recruit group members
- Adjust the group approach
- Develop a course and schedule
- Prepare visual aids
- Select reference materials and handouts
- Deliver training
- Provide after-session support as needed
- Keep up-to-date regarding relevant knowledge
- Be flexible

6.12

During Each Session

- Provide a welcoming atmosphere
- Encourage questions and comments
- Provide sources of additional information
- Remain in the room afterward
- Talk to people with problems or concerns

6.13

Considering Learning Styles

- Age
- Education level and fluency
- Stage of treatment or recovery
- Didactic vs. interactive
- Visual vs. auditory

6.14

Tailoring Instruction

- Variety
- Visual aids
- Role-plays
- Videos

6.15

General Training Guidelines for Group Leader

- Periodically review information
- Use common language
- Break information down
- Check for understanding

6.16

Cognitive Deficits

- Common in early recovery
- Particular effect on:
 - Short-term memory
 - Attention span
- Helped by repeating information

6.17

Avoid Overt Triggers

- CRITICAL!!!

- No:

- ▣ Drug images
- ▣ Paraphernalia images
- ▣ Images of substance use or drinking

6.18

Countering Triggers – What to do?

- Stay after group
- Call a family member



6.19

Break

15 minutes

6.20

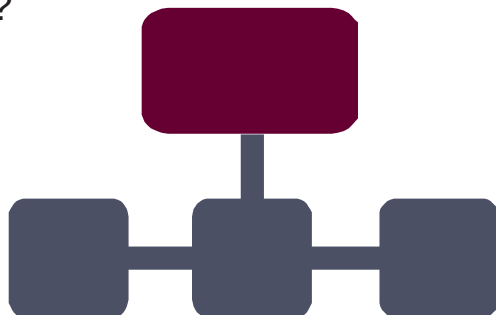
Potential Topics

- Information about specific substances
- Relapse prevention
- Finding supports
- Avoiding triggers
- Others?

6.21

Small - group exercise: Psychoeducation Groups

- What are the challenges and barriers one would experience in forming a psychoeducation group in your community?
- How would you overcome these challenges and barriers?



6.22

Typical sequence of topics addressed in psychoeducational group

Treatment Engagement:

- Understanding motivation and committing to treatment
- Counteracting ambivalence and denial
- Determining the seriousness of the drug or alcohol problem
- Conducting self-assessment, setting goals, and self-monitoring progress
- Overcoming common barriers to treatment

Early Recovery:

- Dealing with special issues such as lingering physical effects and cravings

Maintenance and continuing care:

- Help client maintain abstinence and prevent relapse

6.23

Small-group Exercise: Stages of Treatment

- Note all psychoeducation topics you think would be appropriate for your assigned stage of treatment
- Grab another sheet of newsprint if you need it!

6.24

Reflective Exercise

- Did anything you learned today surprise you?
- What will you be most likely to use in your practice?
- What burning questions do you still have about working with groups?

6.25

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**MODULE 6—PSYCHOEDUCATION
GROUPS FOR CLIENTS AND FAMILIES**

**DAP**
Drug Advisory Programme

Family Groups

- Include a wide range of people
- Can re-establish relationships
- Can help family support recovery
- Help members realize that their situation is not unique

6.27

Goals: Specific

- Present accurate information
- Discuss how recovery affects families
- Enable families to discuss recovery
- Correct any misunderstandings about substances or recovery
- Promote self-care
- Convey dignity and respect

6.28

Topics Specific to Family Groups

- SUDs and families
- Putting the family back together
- Rebuilding trust
- Family roles
- Families in recovery
- Living with an SUD
- Communication traps

6.29

Large-group Discussion: What Are Your Programs Doing?

- Do you offer psychoeducation?
- What types?
- Is there anything you want to change?

6.30

Module 6—Psychoeducation Groups for Clients and Families – Summary

Introduction

- Psychoeducational groups educate clients about substance abuse and related behaviors and consequences. This type of group presents structured, group-specific content, often taught using videotapes, audiocassette, or lectures. Frequently, an experienced group leader will facilitate discussions of the material.
- Psychoeducational groups:
 - Educate clients about substance abuse: That is, provide information about such topics as specific substances and addiction.
 - Educate clients about related behaviors and consequences: Here we're talking about how substance use can lead to behaviors that interfere with the lives of people who use substances, their families, employment, and other parts of their lives.
 - Present structured, group-specific content: Psychoeducation follows a set curriculum and schedule, unlike group therapy and other forms of treatment.
 - Often use visual aids: Like videotapes or brochures, CDs, or lectures.
 - Facilitate discussions: An experienced group leader plays a major role in the group.
- There are a few similarities between psychoeducation and the group treatment approach:
 - Each type of group consists of two or more individuals—clients—who have similar characteristics. In our case, these characteristics are substance use disorders (SUDs).
 - The group members have a common goal: recovery.
 - Accordingly, the focus of each type of group is on SUDs and recovery.
 - Each group is facilitated by a trained, experienced leader.
 - Each group encourages some level of interaction among clients.
- You could make the same comparisons with family treatment, adding the focus on relationships.
- However, there are some very important differences between the two types of groups:
 - As the name implies, psychoeducation focuses on education. These groups are not the place for a discussion of experiences, emotions, personal problems, or relationships.
 - The emphasis is on information, knowledge, and thoughts. This is not the place to talk about feelings.
 - Also included is skill building as it relates to recovery.

- For example, a psychoeducation group may discuss how brain chemistry can cause cravings. In group treatment, clients may describe their own cravings and help one another learn how to deal with them.
- Clients should receive both psychoeducation and group treatment (and perhaps family treatment). They can then address their disease from both intellectual and emotional perspectives.
- Remember, the purpose of psychoeducation is not to give clients individual guidance or address one person's or family's issues in these areas. The idea is to present ideas that participants can use to supplement their therapy. This includes skill building to support recovery.
- Skill building here is differentiated from personal therapy in that it includes skill-based topics relevant to recovery that most (if not all) clients can benefit from. These may include problem-solving, avoiding triggers and cravings, and other skills related to relapse prevention.
- Sometimes clients feel a need to get the emotional support or a chance to express themselves that group treatment can give them. And it can be easy for leaders to start running the psychoeducation group like treatment. It's very important to resist this temptation and keep focusing on ideas, not individuals.
- Finally, the leader can talk to treatment personnel to discuss how these topics are handled in therapy groups and how they can best be coordinated with treatment. Of course, the leader might be facilitating therapy groups himself or herself, so this won't be necessary.
- A very important consideration is the structure of the group: who will be in it?
- Some psychoeducation groups consist only of clients in the treatment program. These groups may focus on substance information, education on a variety of relevant topics, and skill building as it relates to recovery.
- Family psychoeducation, as the name suggests, involves clients' family members. The groups may or may not include the clients. Family groups are important not only to educate the family about different aspects of SUDs and recovery, but also to educate them on what to expect and how they can best support their family member in recovery.
- This may include groups offered in schools, houses of worship, or work settings.
- We can also generalize and say there are two types of psychoeducation groups: skills-based and information-based.
- Skills-based groups are a type of psychoeducation that focuses on teaching clients specific recovery skills rather than providing information. These skills might include:
 - Problem-solving where clients are taught to use a seven-step problem-solving process;
 - Techniques for managing cravings such as relaxation, visualization and other thought-stopping techniques;

- Refusing drug offers - teaching clients refusal skills or how to say no to drug offers; and
 - Other relapse-prevention strategies such as time management and practicing self-care .
 - Emotion regulation techniques.
- Information-based groups have the following characteristics:
- The group focuses on increasing knowledge rather than developing skills. For example, discussion on drug classification, health impacts of substance use or progression of addiction.
 - The leader uses a didactic approach, much like a traditional teacher.
 - The information tends to be more specific because of the emphasis on information.
 - Although the trainer encourages group interaction, such as by asking questions, there is less interaction than in a skills-based group.
 - There is no discussion of personal issues (there might be some in a skills-based group).

Leadership

- The most important factor affecting the quality of the group is, of course, the leadership
- Some qualifications needed of the leader:
- To begin with, leading a psychoeducation group can be hard work. The leader must be motivated and interested in providing quality service.
 - Similarly, the leader must care about the participants. If he or she does not, it will be clear to participants, and they will get less out of the group.
 - Experience is important, of course. One plus is having led other types of training, which can broaden one's skills. Another is having led other kinds of groups, such as group therapy for people with SUDs. This experience helps the leader provide training that supports the participants' therapy.
 - The leader should know how the psychoeducation services fit into the agency's overall treatment approach.
 - Finally, whether as a counselor or trainer, the leader should have experience with the kinds of clients and families who will participate in the groups.
 - Trained professional, with experience and skills in group management and addiction.

¹²Weiss NH, Forkus SR, Contractor AA, Schick MR. Difficulties regulating positive emotions and alcohol and drug misuse: A path analysis. *Addictive Behaviors*. 2018 Sep; 84:45-52. DOI: 10.1016/j.addbeh.2018.03.027.
 Choopan, H., Kalantarkousheh, S. M., Aazami, Y., Doostian, Y., Farhoudian, A., & Massah, O. (2016). Effectiveness of Emotion Regulation Training on the Reduction of Craving in Drug Abusers. *Addiction & health*, 8(2), 68–75.

- We talk about the trainer needing experience. Of course, every trainer has led a psycho- education group for the first time. But even then, the leader should have a background in training or counseling—or both—that is the basis of the skills needed for this work.
- Here are some of the general tasks that leaders perform:
 - Decide which clients the group will be designed to serve, then help select specific participants who will benefit most from that group.
 - Help the agency or other programs recruit potential members.
 - After the members have been selected, take another look at the overall plan for the group to make sure it is right for these participants.
 - Develop a course and schedule, such as the one we talked about earlier.
 - Prepare PowerPoint slides and other visual aids.
 - Select reference materials and handouts.
 - Then, of course, provide education.
 - Provide after-session support as needed.
 - Stay up-to-date regarding information and knowledge about substances, SUDs, and recovery
- Sometimes, the leader must go above and beyond these duties, because some participants may need help outside of the group, such as clarifying information or obtaining additional support. The leader must therefore be flexible, because he or she will sometimes need to provide these extra services.
- There are some things the leader can do during each session to enhance the experience for the participants:
 - Always provide a welcoming atmosphere that makes the participants feel comfortable.
 - Encourage participants to answer questions and make comments (although it's important to keep the training on track and be sure that one individual doesn't start dominating the group).
 - Provide sources of information, primarily through handouts, for people who want to learn more about a certain topic. This might include referrals to other parts of your agency or to other programs.
 - As we've said, remain in the room after the session in case anyone needs to talk to you. A lot of learning can take place in after-group meetings.
 - Invite people to bring up problems or concerns, although it may be appropriate to delay responses until after the meeting when the leader can meet with participants privately. Note that not everyone is comfortable asking questions in a group setting.

- Participants: Everyone has a different learning style, and an effective trainer can modify the approach accordingly. Although each individual is different, here are some of the general factors that affect learning styles:
 - Age: Adolescents learn differently from adults, and young adults differently from older people.
 - Education level and fluency in the language affect how basic or advanced the information can be.
 - Stages of treatment or recovery: We'll talk about this in a minute.
 - Didactic versus interactive: Some people prefer a lecture type of training, whereas others learn better from interaction with the leader or other participants.
 - Some learn better visually and are helped by visual aids, such as slides. Others do better with spoken material and thus prefer lectures.
- It is necessary to strike a balance in teaching styles to accommodate different kinds of learners.
- Here are some ways leaders can compensate for different learning styles:
 - Become familiar with participants' learning styles, both when recruiting and in initial group meetings. Get a sense of how they learn, and tailor education accordingly.
 - Use a variety of presentation styles and aids to meet the needs of participants.
 - Use lecture sparingly, and include visual aids, such as PowerPoint presentations, newsprint, and posters.
 - Use role-plays—although sparingly—with instructions that will encourage participants to focus on information, not personal experience.
 - If videos are available, use those that present information on the subject at hand.
- Additional techniques use in response to the group's learning styles include the following:
 - Periodically review information to reinforce messages. It may be hard for participants to remember everything the first time around.
 - Be careful not to use academic or professional language that people may not understand.
 - Break information down into small chunks instead of giving it all at once.
- Check for understanding through such techniques as asking questions about the material you've just presented.
- Some people in early recovery may have trouble understanding or remembering content because of lingering drug effects or the effects of withdrawal on their cognitive abilities. Common cognitive deficits in early recovery include memory loss and short attention span.

- These problems particularly affect short-term memory—exactly the kind of memory they need to have to learn from a training group. Therefore, a group with people in early recovery must be structured accordingly, particularly by repeating information in different ways, in different group contexts, and over the course of the client’s treatment.
- This approach helps clients comprehend and retain basic concepts and skills critical to recovery.
- In the early part of treatment, sessions also should be kept short (no more than 20 minutes) because of the short attention span of many clients.
- A very important principle is not to use images in materials that could trigger cravings. These could include pictures of drugs, paraphernalia, or people using drugs or drinking. Sometimes talking about substances in the group can be a trigger for some of the participants. There is therefore a danger that the psychoeducation could increase the risk of relapse.
- The first thing to do is try to identify anyone who might be having trouble. You might be able to tell from one’s reaction to the discussion, such as facial expression or body language. You can also ask a very frank question: “Is anyone uncomfortable with this subject? Is it making you think of using?”
- Clients in outpatient programs may be at greater risk for experiencing situations that trigger cravings. Here are some other possibilities for countering triggers in an outpatient setting:
 - You may need to stay after the group with the person, spending time with him or her until the craving passes. Encourage the person to talk it out; use active listening and perhaps reframing to help them see their craving in a different way.
 - Finally, it can help to have the person call a family member or other person he or she lives with and make a commitment to be home at a certain time. This commitment can be an incentive for the group member to go straight home. This works best if the family member has attended education sessions and will know how to respond.
 - In some Latin American countries, triggers of cravings are also called detonators (detonates), precipitants (precipitantes), or desesperados.

Psychoeducation content

- We’ve talked about various aspects of psychoeducation, including the nature of groups and how to lead them. Now let’s talk about content: what information should the group cover?
- Some of the topic areas that should be addressed include:
 - Information about specific substances - drug classification, the withdrawal effects and health impacts;
 - Relapse prevention - understanding the concepts of lapse versus relapse, and recovery, managing cravings;

- Finding supports - understanding the importance of support groups in recovery, connecting with AA/NA and other self-help-mutual help groups; and
- Avoiding triggers - understanding triggers and skills to manage triggers.
- Sexuality; reproductive health; sexual beliefs;
- Effects of substances;
- Dealing with loss and trauma;
- Mood and emotion management;
- Self-concept;
- Disease concept and management; and
- Codependency.

Psychoeducation and Stages of Treatment

- Typical topics that are covered in psychoeducational groups and the treatment stage at which they are introduced:
 - Treatment engagement: when we are working to motivate the client to sincerely enter and commit to treatment. The focus at this stage of treatment is to help the client counteract ambivalence and denial, to determine the seriousness of the drug or alcohol problem. To conducting self-assessment, setting goals, and self-monitoring progress and overcoming common barriers to treatment. This may include working with someone in the precontemplation stage of change. Note that being physically present is not necessarily the same as being engaged in treatment. Engagement means getting a client involved and participating in a way that is meaningful to him or her.
 - Early recovery: when we deal with the special issues involved in this stage, including lingering physical effects and managing cravings. The client is in the preparation and action phase of treatment. Ongoing recovery: when we help the client maintain abstinence and prevent relapse. This is also known as the maintenance phase of treatment.
 - There are advantages to having separate psychoeducation groups for clients in a particular stage of recovery, but that is usually not possible. On the other hand, there is an advantage to having clients in different stages in the same group: Clients further along in the process can reinforce the information: "Yes, that happened with me," or "I thought I'd never make it, but I did."

Possible topics for Treatment Engagement¹³

- Understanding motivation and committing to treatment
- Counteracting ambivalence and denial
- Determining the seriousness of the drug or alcohol problem

- Conducting self-assessment, setting goals, and self-monitoring progress
- Overcoming common barriers to treatment

Possible topics for Early recovery

- Learning about biopsychosocial disease and recovery processes
- Understanding the effect of specific drugs and alcohol on the brain and body
- Placing symptoms of substance use disorders in the context of other behavioral health problems
- Learning about early and protracted withdrawal symptoms for specific drugs and alcohol
- Knowing the stages of recovery and the client's place in the continuum of care
- Learning strategies for quitting and finding the motivation to stop
- Minimizing risks of HIV/AIDS, hepatitis C, and sexually transmitted diseases (STDs)
- Identifying high-risk situations that are cues or triggers to substance use: people, places, and things
- Identifying peer pressures and compulsive sexual behavior as triggers
- Understanding cravings and urges, learning to extinguish thoughts about substance use, and coping with cravings
- Structuring personal time Coping with high-risk situations
- Understanding abstinence and the use of prescription and over-the counter medications
- Understanding the goals and practices of various 12-Step or other mutual-help groups
- Identifying and using positive support networks

¹³: Center for Substance Abuse Treatment. Substance Abuse: Clinical Issues in Intensive Outpatient Treatment. Treatment Improvement Protocol (TIP) Series 47. 2006

Maintenance and continuing care

- Understanding the relapse process and common warning signs
- Identifying tools to prevent relapse
- Developing personal relapse plans
- Counteracting euphoria and the desire to test control
- Improving coping and stress management skills
- Learning anger management and relaxation techniques
- Enhancing self-efficacy for handling risky situations
- Responding safely to slips and avoiding escalation
- Finding recovery resources
- Structuring leisure time and finding recreational activities
- Knowing the importance of personal health: diet, exercise, hygiene, and check-ups
- Taking a personal inventory
- Handling shame, guilt, depression, and anxiety
- Understanding family dynamics: enabling and sabotaging behaviors
- Rebuilding personal relationships
- Understanding sexual dysfunction and healthy sexual behavior
- Developing educational and vocational skills
- Learning daily living skills: money management, housing, and legal assistance
- Embracing spirituality and recovery and finding meaning in life
- Recognizing grief and loss and the relationship to substance use
- Learning about parenting: basic needs of children and their developmental stages and developmental tasks
- Maintaining balance in life

Family psychoeducation

- The principles are the same as for information-based client groups. But psychoeducation for families can be a very important part of a treatment program, so let's talk about that.
- The term "family" includes a very wide range of people. The family might include a romantic partner, a sponsor, a close friend, or others who are close to the client and are concerned with his or her recovery.

- Although the information-based group is not family therapy, it can help re-establish relationships as the family learns that the client is suffering from a disease and that there is hope.
- Similarly, the group can help support recovery—the family members learn more about what recovery involves and how they can help the client through the process.
- Finally, family members often feel that their relative's SUD is their fault, and they feel guilty. They may also believe that they are the only ones who are going through this. The psychoeducation can help them understand that it is not their fault, and they are not alone. In fact, psychoeducation can help them understand that many other families are experiencing the same feelings, so they may feel less guilty and hopeless.
- Family psychoeducation should:
 - Present accurate information, particularly on such topics as how substances affect behavior;
 - Discuss the interaction between recovery and the family and the family's involvement in the process;
 - Give families an opportunity to discuss recovery as they understand it, correcting any misunderstandings they may have;
 - Encourage family members to care for themselves even as they support the client; and
 - Convey dignity and respect to help them overcome feelings of shame or guilt they may have about the client's SUD or behavior. Families need to learn to address and overcome these feelings.
- Many of those topics apply to family groups, as well. Then there are some topics specific to family groups. For example:
 - SUDs and families: How an SUD affects the whole family, not just the person who is using substances;
 - Putting the family back together: How other families have started to rebuild the relationships and functioning that the member's SUD may have damaged;
 - Rebuilding trust: The important role that trust plays in recovery and how families have achieved this important step;
 - Family roles: The roles family members may assume in response to a member's SUD;
 - Families in recovery: The process of recovery and how families can work together to prevent relapse;
 - Living with an SUD: How to cope with a family member who is using substances, particularly when relapse occurs; and

- Communication traps: The important role that communication plays in healthy families and the problems that can occur. Many families don't know what to say or how to avoid relapse triggers.
- It is important to remember here that this is not family therapy. However, counselors who conduct family education must be skilled at working with families and have knowledge of issues relevant to families of clients with an SUD.
- The purpose is usually not to address families' own feelings in depth, but to focus on how families in general experience these feelings. The family can then explore issues personally in family therapy.

MODULE 7

TEACHING CLIENTS SKILLS

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Content and Timeline	
Activity	Time
Introduction to Module 7	10 minutes
Small-group presentations: Principles of effective skills training	70 minutes
Small-group demonstrations: Specific skills	120 minutes
<i>Lunch</i>	<i>60 minutes</i>
Partner exercise: Practicing skills training	45 minutes

Module 7 Goals and Objectives

Training goals

- To provide basic rationale and principles for client skills training; and
- To provide information and practice in teaching clients specific skills.

Learning objectives

Participants who complete Module 7 will be able to:

- List and describe at least five principles of effective skills training;
- Describe and demonstrate teaching refusal skills;
- Describe and demonstrate teaching time management;
- Describe and demonstrate teaching thought-stopping techniques; and
- Describe and demonstrate teaching problem-solving techniques.



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CURRICULUM
Treatment of Substance Use Disorders

The Universal Treatment Curriculum for Substance Use Disorders (UTC)

UTC 4

Basic Counseling Skills
for Addiction Professionals



MODULE 7—TEACHING CLIENTS SKILLS



DAP
Drug Advisory Programme

Skills Training

- *Systematically* teaches clients specific skills:
 - ▣ Purposeful
 - ▣ Orderly
 - ▣ Step-by-step procedures
- Coaches clients to manage their recovery



7.2

Skills Training (continued)

- Learning new skills is critical to foster clients' abilities to achieve and maintain recovery
- Learning skills can help clients throughout their lives

7.3

Module 7 Learning Objectives

- List and describe at least 5 guidelines for effective skills training
- Describe and demonstrate teaching refusal skills
- Describe and demonstrate teaching time management

7.4

Module 7 Learning Objectives (continued)

- Describe and demonstrate teaching thought-stopping techniques
- Describe and demonstrate teaching problem-solving techniques

7.5

Small-Group Presentation: Principles and Guidelines for Effective Skills Training

- Resource Page 7.1: Principles and Guidelines for Effective Skills Training
- Form 4 small groups
- Read your group's assigned topics
- Prepare a 3- to 5-minute presentation on each topic
- Be creative!

7.6

Small-group Demonstrations: Skills

- Introduce your skill topic: Why is it important?
- Prepare a teaching demonstration:
 - ▣ Use Resource Page 7.1: Principles and Guidelines for Effective Skills Training
 - ▣ You can include parts of more than one session with a client (part of an initial teaching session followed by a later session to demonstrate followup, for example)
 - ▣ You may want to demonstrate a way in which the skill could be taught in a group setting

7.7

Lunch

60 minutes

7.8

Partner Exercise: Practicing Skills Training:

- Select a partner
- Select a skill you want to practice as a client
- Decide who will be the “counselor” first
- Practice for 5 to 10 minutes
- Switch roles

Switch roles and skills as often as you want.

7.9

Resource Page 7.1: General Principles and Guidelines for Effective Skills Training

General Principles

- The content and timing of skills training need to be highly individualized, depending on the client's stage of change, goals, and circumstances.
- The counselor should not rush through skills-training material to try to cover all of it in a short time; some clients may need several weeks to master a basic skill. Working at the client's pace is more effective than rushing the client and risking the therapeutic relationship.
- Counselors should use language that is compatible with the client's level of understanding and sophistication.
- Counselors should frequently ask clients whether they understand a concept and whether the material is relevant to them.
- The counselor should be alert to signals from clients who think the material is not well suited to them. Signals include avoiding eye contact, overly brief responses, failure to provide examples, failure to do homework, and so on.
- One important way to ensure that skills training is relevant to a client is to use specific examples and situations provided by the client.

Guidelines

1. Model Skills and Help Clients Practice

- Modeling helps a client learn new behaviors by participating in role-plays with the counselor during treatment.
- A client learns to respond in new, unfamiliar ways by first watching the counselor model those new strategies.
- After the counselor has modeled a new skill, the client can practice those strategies in the supportive context of the relationship.

2. Use Repetition

- People master complex new skills by trying them out, making mistakes, identifying those mistakes, and trying again.
- It is important that counselors recognize how difficult, uncomfortable, and even threatening it is to change established habits and try new behaviors.
- For most people, mastering a new approach to old situations takes several attempts.

¹Primary source: Carroll, K. M. (1999). *Therapy manuals for drug abuse: Manual 1, A cognitive-behavioral approach—Treating cocaine addiction*. NIH Publication Number 99-4309. Bethesda, MD: National Institute on Drug Abuse.

- Clients may have problems with attention, concentration, and memory because of drug use.
- Repetition may be necessary to help clients understand and retain new material.
- Some people may need counseling at a time of crisis (for example, learning that they are HIV positive or that they have lost their jobs). These people may be so preoccupied with their current problems that focusing on the counselor's thoughts and suggestions is difficult.

3. Get a Commitment

- It is important that clients practice new skills outside the sessions.
- The counselor should get a commitment from the client to practice new skills.
- The counselor should not expect a client to practice a skill without understanding why the skill is helpful.
- The counselor needs to stress the importance of out-of-session practice.
- The counselor should be direct and ask clients whether they are willing to practice skills outside the sessions and whether they think doing so would be helpful.
- A client's hesitation or refusal may signal issues that are important to explore with the client, such as ambivalence about stopping drug use, fear of failure, or simply not understanding the task.
- Example:
 - It is important for us to talk about and work on new skills when we meet, but it is even more important to put these skills to use in your daily life. You are the expert on what works and doesn't work for you, and the best way to find out what works is to try it out. Are you willing to try _____ before we meet again?

4. Anticipate Obstacles

- The counselor should help clients anticipate obstacles they may encounter in carrying out practice assignments and apply a problem-solving strategy to help work through these obstacles (more about problem solving later in the module).
- Clients should be active participants in this process.
- The counselor should ask questions like:
 - What might be hard about practicing this skill this week?
 - Do you see any reasons why you may not be able to practice this skill this week?
 - What will be hardest about telling Dong you can't go to the karaoke bar with him tonight?

5. Monitor Closely and Use the Information

- Monitoring homework assignments is critical to enhancing learning.
- Checking on task completion underscores the importance of practicing coping skills outside the sessions.
- Monitoring provides an opportunity to discuss the client's experience with practicing the tasks so that any problems can be addressed.
- Clients are more likely to practice an exercise if they expect the counselor to ask about a practice experience.
- Monitoring assignments involves more than simply asking whether the client completed it. Counselors should explore:
 - When the client practiced the assignment;
 - How it went;
 - How the client felt about it; and
 - What the client learned about himself or herself in carrying out the task.

6. Explore Resistance

- Asking why a client did not complete an assignment is also important. A client may give several reasons for not practicing. For example:
 - I didn't have time.
 - I forgot.
 - I didn't feel like it.
 - I needed to do something for a friend.
- Some of the underlying reasons may be:
 - He or she may feel hopeless and not think it is worth trying to change behavior.
 - He or she may expect change to occur through willpower alone, without making specific changes in particular problem areas.
 - His or her life is chaotic and crisis ridden, and he or she is too disorganized to carry out the tasks.
- By exploring the specific nature of a client's difficulty, a counselor can help the client solve problems.

7. Praise Approximations

- “Praise approximations” means to reinforce the client for even the smallest attempts or steps in the right direction.
- Clients will not always complete all practice exercises.
- The counselor should try to shape the client’s behavior by:
 - Praising even small attempts at working on assignments;
 - Highlighting anything clients reveal that was helpful or interesting in carrying out the assignment;
 - Restating the importance of practice; and
 - Developing a plan for completion of the next session’s homework assignment.
- Examples of praising approximations:
 - OK, so you went to the bar with your friend Friday night instead of telling him you couldn’t go. But you left early because you started feeling uncomfortable—that’s great!
 - I’m glad to hear you thought about whom you could call in an emergency. Maybe this week you can get that list on paper!

Resource Page 7.2: Refusal Skills

Ideally, a recovering person will avoid high-risk situations and people completely. However, that is not always practical or possible. For example:

- Some people, like drug dealers, will have a financial incentive to keep the recovering person in the drug-using world and may even try to find the person.
- A client may be in a close, intimate relationship with someone who still uses drugs and may be unwilling or unable to avoid this person.
- The client may be offered drugs by someone he or she doesn't know.

The counselor can help the client maximize the chances of staying in recovery by teaching refusal skills or how to say no to drug use. The counselor can tell the client there are several ways to say no:

- By simply leaving the scene—either quietly while no one notices or by making an excuse or joke out of it: “You guys are too crazy for me. See you later.”
- By being direct and definite: “No. I don’t do drugs anymore.”
- By negotiating and setting limits: “Listen, I’ve decided to stop, and I’d like you not to ask me to use with you anymore. If you can’t do that, I think you should stop coming over to my house.”

The counselor can explore with the client which response is best for each situation and person, as well as the extent to which exposure to drugs can be renegotiated. For example:

So, you feel as if you want to stay with your boyfriend for now, but he’s not willing to stop using heroin. Being with him is pretty risky for you, but maybe we can think of some ways to reduce the risk. Have you thought about asking him not to bring drugs into the house or use in the house? You’ve said you know it’s hard for you that he continues to do that, in terms of your staying abstinent and having drugs around your kids.

The counselor also can help the client by educating him or her on non-verbal and verbal ways of saying no effectively. For example:

- Look directly at the person when you answer to increase the effectiveness of the message.
- Stand or sit up straight to create a confident air.
- Don’t feel guilty about the refusal; you aren’t hurting anyone by not using.
- Use a clear, firm, confident tone of voice.
- “No” should be the first word out of your mouth.
- Suggest an alternative activity if you want to do something else with that person.

- Tell the person offering you drugs not to ask you now or in the future so the other person stops asking.
- Change the subject to something else.
- Avoid vague answers; they imply you will change your mind later.
- Walk away if the other person insists.

Safety needs to be considered. Saying no to one's former drug dealer may carry some risk, for example. In these cases, vague answers may be safer than more direct and decisive responses. For example:

- I'm not feeling well today.
- My boss is really watching me lately.
- I have to take care of my sister's kid.
- I don't have the money today.

Saying no can be difficult, and the counselor can best help the client by role-playing with him or her. To do this, the counselor should:

- Pick a concrete situation that occurred recently for the client;
- Ask the client to provide some background on the target person;
- Have the client first play the target individual so that the counselor can get an idea of the style and likely responses of the person who offers the drug and can model effective refusal skills;
- Reverse the roles so the client can practice; and
- Process the role-play with the client, praising any effective refusal skills shown by the client and suggesting alternatives when necessary. For example:

That was good! How did it feel to you? I noticed that you looked me right in the eye and spoke right up; that was great. I also noticed that you left the door open to future offers by saying you had stopped shooting up for a while. Let's try it again, but this time, try to do it in a way that makes it clear you don't want your sister to offer you drugs ever again.

Resource Page 7.3: Time Management

When a person has a substance use disorder, his or her life is structured around finding ways to pay for drugs, using drugs, and recovering from drug use. Or, if a person has been in a treatment program or jail, his or her schedule has been dictated by others. Once a person is in recovery or leaves a protected environment, his or her life is suddenly unstructured. This lack of structure can be dangerous to the recovering person.

Learning time management and scheduling skills can help people in recovery:

- Feel more in control of life and reduce anxiety;
- Avoid triggers;
- Counter the drug-using lifestyle; and
- Provide a basic foundation for ongoing recovery.

Making a daily plan of activities that promote recovery reduces the possibility of boredom, impulsive decision-making, exposure to triggers, and relapse. The counselor can help clients create a realistic daily schedule using a planning book or calendar page (see sample schedule page at the end of the Resource Page).

One of the main goals of scheduling is to ensure that the rational part of clients' brains takes charge of their behavior rather than the emotional, addicted part of their brains where cravings start. When clients make a schedule and stick to it, they put their rational brains in charge. People need to learn to structure their time if they are serious about recovery.

It is important for clients to plan their activities and to **write them down**. Schedules that exist only in one's head are too easy to revise or abandon. Scheduling every hour of the day and sticking to the schedule can be a big help for clients in early recovery. When clients are making their schedules, special attention should be paid to weekends and any other times clients feel they are particularly vulnerable to substance use.

The counselor can help clients learn to schedule by:

- Educating them as to why it is important;
- Helping them think through possible daily activities to include on a schedule;
- Helping them identify potential problems (such as a time when they are most vulnerable to relapse); and
- Helping them evaluate how well the schedule worked.

The counselor can help clients start small (e.g., scheduling only part of the current day), and move on to developing more comprehensive daily or even weekly schedules. Starting with “have to” and routine activities also helps get the process moving. For example:

Counselor: OK, let’s just start with this afternoon. Is there anything you *have* to do?

Client: Well, I have an appointment at the clinic at 15:00.

Counselor: OK, let’s put that on the schedule now. How long do you expect it will take?

Client: Probably about an hour.

Counselor: We’ll put it in the schedule for 15:00–16:00. Anything else?

Client: That’s all I *have* to do. But I usually have dinner with my parents at about 18:00. And there’s a drop-in group I like at 20:00 tonight.

Counselor: Shall we put the drop-in group on today’s schedule?

Client: Sure, I’ll go tonight.

Counselor: We have a great start here! Now, what time do you usually go to bed?

The counselor also can combine scheduling with helping clients develop new, non-drug-using activities by asking questions like:

- Is there anything you used to do and enjoyed before you got so into drugs?
- Would you be interested in getting involved in that again?
- What kinds of things do you think you might enjoy doing that you haven’t tried?

Scheduling time with family members and non-drug-using friends can help clients reconnect and repair relationships as well.

Daily Schedule

Day _____ Date _____

24:00	_____
1:00	_____
2:00	_____
3:00	_____
4:00	_____
5:00	_____
6:00	_____
7:00	_____
8:00	_____
9:00	_____
10:00	_____
11:00	_____
12:00	_____
13:00	_____
14:00	_____
15:00	_____
16:00	_____
17:00	_____
18:00	_____
19:00	_____
20:00	_____
21:00	_____
22:00	_____
23:00	_____

Resource Page 7.4: Thought-Stopping Techniques

Because not all triggers can be avoided, counselors can teach clients some simple thought-stopping techniques to help them quickly interrupt the trigger-craving cycle. These techniques include:

- Visualization;
- Relaxation;
- Rubberband snap; and
- Calling someone.

Not all these techniques work well for all people or at all times. Some people have trouble visualizing, for example, and that technique may never work for them. Someone else may prefer calling someone as a thought stopper, but may not be able to do that if that person is in a meeting at work, for example. Similarly, relaxation or visualization obviously would not be safe when driving. A discreet snap of a rubberband followed by a quick non-using thought may work very well in both those situations.

The counselor should offer clients an opportunity to learn and try all the techniques to ensure that clients have a range of possibilities available at all times.

Visualization

One technique is to visualize a switch or lever and imagine actually moving it from ON to OFF to stop drug- or alcohol-using thoughts. Clients need to know that it is important to have another thought ready to replace the drug- or alcohol-using thoughts. This thought should be pleasurable or meaningful and have nothing to do with drug use. For example, a mother may want to visualize her child smiling at her. Another person may want to think about a particularly beautiful place he or she loves. The counselor should work with the person ahead of time to identify an appropriate thought.

Another type of visualization is called urge surfing: The person visualizes an urge or craving as a wave, watching it rise, crest, and wash onto a beach. This imagery reinforces that urges and cravings usually peak and subside rather quickly if they are not acted on and that the person does not have to be swept away or drowned by the sensations.

Relaxation

Relaxation can help people cope with the emotional and physical sensations of cravings. Cravings often create feelings of hollowness, heaviness, and cramping in the stomach. These feelings often can be relieved by breathing in deeply (filling the lungs with air) and slowly breathing out, repeating the process three times, and focusing on relaxing the body as much as possible for a few minutes.

This process can be repeated as often as the feelings return. Relaxing the body can be combined with visualizing a relaxing scene.

Rubberband Snap

The rubberband technique helps recovering people snap their attention away from thoughts of using drugs or alcohol. It is a classic behavioral conditioning technique that can be used in a wide range of situations.

To use the technique, a person puts a rubberband loosely around his or her wrist. When a craving or using thought occurs, he or she snaps the rubberband lightly against the wrist and says NO (either aloud or to himself or herself) to the drug or alcohol thoughts. As with visualization, people need to have another thought ready to replace the drug- and alcohol-using thoughts.

This technique works best if people leave the rubberband on all the time.

Calling

Calling someone can effectively interrupt cravings. Talking to others provides an outlet for feelings and allows people to hear their thought process. People in recovery should program the numbers of supportive people, including family members, into their mobiles so they can call someone whenever support is needed. Another option is to keep an “emergency card” in your purse or wallet with the name and phone number of someone who has given you permission to call at any time.

Teaching Thought-Stopping Techniques

Counselors can help clients learn to use thought-stopping techniques by:

- Describing and explaining each technique;
- Asking, “What do you think might work best for you?” or “What would you be willing to try this week?”
- Helping the client identify alternative, positive thoughts by asking questions such as, “Could you visualize a place where you always feel comfortable and safe?” or “What is your primary motivation for staying in recovery?” or “Is there something you’re particularly interested in that you could think about?”
- Helping the client identify people he or she could call by asking:
 - Is there someone you can call at any time of the day or night?
 - Who would be most supportive of your recovery?
 - Do you have that number in your mobile?
- Following up with the client at the next visit and asking:
 - How did _____ work for you?
 - Is there another technique you think might work better?

The different techniques require different approaches. For example, the counselor doesn’t have to “teach” the client how to snap a rubberband, and the client probably doesn’t need to practice it in the office. However, the counselor can help the client develop an

alternative thought and talk through when to use the snap. Visualization and relaxation techniques, on the other hand, can and should be practiced in the office. In this case, too, the counselor helps the client develop an effective alternative thought. Calling someone seems obvious, but clients often need to practice calling people when they are not in crisis, so it will feel natural and obvious when they are.

The counselor should emphasize that, if the thought-stopping technique works but the thoughts keep coming back, the person may have to change his or her immediate environment or engage in non-trigger activities that require full concentration. The counselor can offer suggestions and help the client come up with his or her own ideas and plan.

A few examples of non-trigger activities to suggest include:

- Exercise;
- Yoga or meditation;
- Attending a support group meeting;
- Eating or sleeping;
- Recreational activities or hobbies;
- Movies; and
- Spending time with family.

The counselor can help the client identify alternative activities by asking:

- Is there anything you used to do for fun before you used drugs that you might want to try again?
- What do you like to do to relax that doesn't involve using?
- Are there any sports or hobbies you would like to try?

Resource Page 7.5: Problem-Solving

Making the substantial lifestyle changes needed for recovery involves finding solutions for many problems. Some clients may have so many problems that even minor things seem overwhelming. For example, a straightforward goal like going to a job service center to meet a counselor and signing up for assistance may require solving a number of problems: the client may not have readily available transportation, childcare may be needed, or the only available appointments may conflict with other important activities.

For many clients, their drug use has resulted in either avoidance of such problems (simply skipping the job service center appointment) or making impulsive decisions that are not in their best interest (“This isn’t going to work. I’m never going to get a job, so I might as well start using again.”). Such poor problem-solving behavior usually results in negative consequences that increase the severity of existing problems or create additional problems.

Fortunately, clients can *learn* to be effective problem solvers. Counselors can teach clients a six-step problem-solving process. Timing is important, however. Teaching problem-solving works best when the client is in the action stage of change and motivated to learn it and is not impaired (e.g., not actively using alcohol or drugs, not in withdrawal, and doesn’t have significant cognitive impairment).

Problems vary in degree of difficulty and importance, and the time and effort put into problem solving will vary accordingly. However, the *process* of problem-solving is much the same no matter what the problem is.

Step one in the problem-solving model is to let the client know that:

- Problems are normal; everyone has them;
- People can learn to be better problem solvers;
- Resisting the temptation either to respond to a first impulse (or to do nothing) is an important first step; and
- When a problem arises, it is important to stop and think before taking action.

Step two is to identify the problem.

Identifying that there is a problem is usually not too difficult—people tend to know that there is a problem because they feel stressed and anxious. What can be a bit more difficult is defining exactly what the problem is. If clients are unable to clearly define a problem, the counselor can help them learn by guiding them through a process of clarifying the situation.

For example, if a client is upset about his or her current job and is considering quitting, the counselor could ask questions such as:

- How is your relationship with your supervisor?
- Have you received any negative feedback or evaluations?
- What are your relationships like with your coworkers?

More and more detailed questions could be posed to narrow down the problem. Over time, clients can learn to do this process themselves.

Step three is brainstorming possible solutions.

The counselor can guide clients in this step by teaching them the following about brainstorming:

- In brainstorming, it's important to come up with as many solutions as possible.
- Write them all down.
- At this point, do not reject any idea or try to think of just the best idea.
- Use your imagination and think of all possibilities.
- Even ideas that are impractical or clearly not possible may have elements that are useful.
- Do not evaluate plausibility and "do-ability" until all ideas have been identified.

The counselor can guide clients through this process by reminding them when they seem to be judging the options and asking the client "what else?"

Step four is evaluating and selecting a solution.

Now is the time to consider the pros and cons of each possible solution. For each idea, the counselor can ask the client to answer the following questions:

- What is the best possible thing that could happen if you choose this alternative?
- What is the worst possible thing that could happen?
- What is the most likely thing that will happen?
- Would this be a short-term or long-term solution?
- What is your reaction (thoughts, feelings, memories, and future projections) when you think about implementing each alternative?
- Are there any potential negative consequences (both now or in the near future)?
- How much time will it take to carry this out?
- Is it going to require money?
- Do you have the skills to carry this out? Do you have the necessary resources?

- Does this require the cooperation of other people and, if yes, are they likely to cooperate?
- What difficulties might you face when carrying out this solution?
- Which option offers the best outcomes and seems to have the best chance for success?

The actual solution needs to be selected by the client, not the counselor. Clients are the experts in what is the most appropriate choice for them. However, it's important that the counselor not allow clients to undertake solutions that appear inherently dangerous (e.g., confronting a threatening person).

Step five is developing a plan of action.

Many solutions will have several steps. The counselor can help clients break the chosen solution down into manageable steps and determine how and when they will carry out each step (goal setting).

Step six is reviewing progress and evaluating the outcome.

Once a solution is chosen, the counselor should discuss the next step, evaluating its effectiveness. This step emphasizes problem-solving as an ongoing process. It is important that counselors help clients determine how they will know whether a solution is effective. Determining this ahead of time helps clients be more realistic and perhaps optimistic about finding effective solutions to problems.

To help clients evaluate a solution, the counselor can ask or suggest that they consider questions like:

- After you have given the approach a fair trial, does it seem to be working out?
- Are you making progress?
- Has the problem been solved?
- Does the problem need to be re-evaluated?
- Which parts worked best?
- Would you do anything differently next time?
- If not, what could you do to beef up the plan? Or do you need to give it up and try one of the other possible approaches?

Module 7—Teaching Clients Skills, Summary

Introduction

- Skills training can be done in groups or individually. Skills training means systematically teaching clients specific skills, such as time management or problem-solving. A primary goal is to coach clients how to effectively manage their recovery.
- Systematically means being purposeful and orderly; it often involves step-by-step procedures.
- Learning new skills is critical to foster clients' abilities to achieve and maintain recovery. In fact, many of the specific skills we can teach clients are useful for all of us, but we rarely have an opportunity to learn them in a systematic way.
- This module, you will learn ways of teaching clients four basic skills:
 - Refusal skills, or ways of saying “no” to offers of drugs or to risky situations;
 - Time management;
 - Thought-stopping, or specific techniques for managing cravings; and
 - Problem-solving.

General Principles and Guidelines for Effective Skills Training

- See Resource Page 7.1—General Principles and Guidelines for Effective Skills Training.

Specific skills

- See the following Resource Pages for information on specific skills training:
 - Resource Page 7.2—Refusal skills;
 - Resource Page 7.3—Time management;
 - Resource Page 7.4—Thought-stopping, or specific techniques for managing cravings; and
 - Resource Page 7.5—Problem-solving.

MODULE 8

INTEGRATING LEARNING INTO PRACTICE

Content and timeline.	435
Training goals and learning objectives	435
Resource page.	436

Content and Timeline	
Activity	Time
Module 8 and review exercise introduction	10 minutes
Small-group exercise: Developing a practice integration plan	60 minutes
<i>Break</i>	<i>15 minutes</i>
Learning assessment competition	20 minutes
Day 5 wrap up and overall training evaluations	15 minutes
Program completion ceremony and socializing	30+ minutes

Module 8 Goals and Objectives

Training goals

- To encourage participants to think about resources, barriers, and strategies for change
- To provide an opportunity to develop a personal practice integration plan

Learning objectives

Participants who complete Module 8 will have developed a personal practice integration plan.

Resource Page 8.1: Practice Integration Plan

1. The most important thing I learned from this training, and don't want to forget, is:

2. Changes I will make in my practice based on what I have learned are:

3. Some things that could interfere with my plans are (e.g., anticipated barriers):

4. Ways I could overcome these barriers include:

5. The following people (include supervisors, potential mentors, and so on) and resources (further training, reading) could help me in the following ways:

<i>Person or Resource</i>	<i>Possible Ways To Help</i>

APPENDIX A—GLOSSARY

affirming	Making a statement about a person that is sincere and positive. Affirming is like complimenting, but it says something about a person that is deeper than “Your hair looks great!”
ambivalence	Having mixed feelings about something. A normal part of any change process (e.g., wanting to change and not wanting to change).
amplified reflection	A type of reflective listening, amplified reflection adds to simple reflection (see below) by reflecting a client’s statement in an exaggerated, but not sarcastic, form. It may help the client think about what he or she is saying and can move the client toward positive change rather than resistance.
change talk	Any statements from a client that indicate movement in the direction of change, such as vocalizing reasons for change. The more a client, rather than a counselor, makes arguments for change: ■ The more he or she will believe change is needed; ■ The stronger his or her commitment will be; and ■ The more likely he or she is to actually make a change.¹
counter-transference	An unconscious process in which a counselor transfers onto clients his or her own feelings and attitudes about other people in her past or present personal life. Counter-transference can happen in response to a client’s issues that also trouble the counselor, or when a client strongly reminds the counselor of someone significant in the counselor’s early life.
DARN-C ¹	An acronym for a model of looking at types of change talk: ■ Desire to change; ■ Ability to change; ■ Reasons to change; ■ Need to change; and ■ Commitment to change.

¹Amrhein, P. C., Miller, W. R., Yahne, C. E., Palmer, M., & Fulcher, L. (2003). Client commitment language during motivational interviewing predicts drug use outcomes. *Journal of Consulting and Clinical Psychology*, 71(5), 862–878.

decisional balancing	A structured process of cognitively appraising or evaluating the “good” aspects of substance use—the reasons <i>not</i> to change; and the less good aspects—the reasons <i>to</i> change.
double-sided reflection	A type of reflective listening (see below), double-sided reflection acknowledges what a client has said, but also states contrary things he or she has said in the past. A “yes, but what about...” approach.
dual relationship	A dual relationship exists when a counselor serves in the capacity of both counselor and at least one other role (e.g., social, financial, professional) with the same client. A dual relationship can occur at the same time as the helping relationship or after the helping relationship has formally ended.
helping (or therapeutic) relationship	The relationship between a counselor and a client; the means by which the professional hopes to engage with, support, and facilitate change in a client.
open-ended questions	Questions that: ■ Cannot be answered “yes” or “no”; ■ Cannot be answered with one or two words; and ■ Are not rhetorical (meaning questions that are asked more to make a point than in expectation of an answer). Sometimes are not even framed as a question: “Tell me more about....”
psychoeducation group	“Psychoeducational groups educate clients about substance abuse and related behaviors and consequences. This type of group presents structured, group-specific content, often taught using videotapes, audiocassette, or lectures. Frequently, an experienced group leader will facilitate discussions of the material.” ¹
reflective listening	Reflective listening involves making a reasonable guess about what a client means, then rephrasing the client’s statement to reflect what the counselor thinks he or she heard, giving the client a chance to clarify when necessary. There are three main types of reflective listening: simple reflection, amplified reflection, and double-sided reflection.

¹Center for Substance Abuse Treatment. (2005). *Substance abuse treatment: Group therapy*. Treatment Improvement Protocol (TIP) Series 41. HHS Publication No. (SMA) 05-3991. Rockville, MD: Substance Abuse and Mental Health Services Administration.

rolling with resistance	A concept from Miller and Rollnick's motivational interviewing material¹ that views client resistance as: An indicator of ambivalence (see above), a normal part of any change process; and A signal that the counselor needs to change direction with or listen more carefully to the client, or "roll" with the resistance rather than confronting it.
self-efficacy	A person's belief in his or her ability to succeed in a particular situation. Term coined by social psychologist Albert Bandura.
simple reflection	A type of reflective listening (see below) that involves reflecting a client's statement back to him or her in a simple, neutral form without just repeating the client's words verbatim. Conveys understanding of the client.
transference	An unconscious process where attitudes, feelings, and desires from a client's very early significant relationships get transferred onto the counselor. As a helping relationship deepens, the situation may trigger familiar feelings related to the client's previous connections with other significant people. The client may then begin to experience the counselor in much the same way the client experienced a significant person from his or her past.

¹Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford Press.

APPENDIX B—RESOURCES

Global Drug Use Statistics

United Nations Office on Drugs and Crime, World Drug Report 2020. Available at <https://wdr.unodc.org/wdr2020/>

World Health Organization. (2010). *Management of substance abuse: The global burden*. Geneva: Author. Retrieved December 10, 2010, from http://www.who.int/substance_abuse/facts/global_burden/en/index.html

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Counseling Skills

Addiction Technology Transfer Centers Website
<http://www.attcnetwork.org/index.asp>

American Group Psychotherapy Association Website
<http://www.agpa.org/>

American Group Psychotherapy Association Science To Service Task Force. (2007). *Practice guidelines for group psychotherapy*. New York: American Group Psychotherapy Association.
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<http://www.basic-counseling-skills.com/>

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